SPINAL CORD DYSFUNCTION (SCD)

USER MANUAL

Version 2.0

February 2000

Revised December 2002

Department of Veterans Affairs
VISTA Technical Services

Revision History

Date	Revision	Description
December 2002	Revision	Document reviewed and updated.
January 2003	Patch SPN*2.0*19	Enhancements

Table of Contents

Introduction

Overview

The Spinal Cord Dysfunction (SCD) package, a component of the Veterans Health Information Systems Technology Architecture (VISTA), is a software product that permits the identification and tracking of patients with a spinal cord dysfunction due to trauma or disease and the medical resources utilized during their treatment. The programs and files support the maintenance of a local and national registry for patients with a spinal cord dysfunction. The package also provides clinical, administrative, and ad hoc reports for medical center use.

The SCD package accesses several other VISTA files, which contain information concerning diagnosis, prescriptions, lab tests, radiology exams, hospital admissions, and clinic, visits. This allows your clinical staff to take advantage of the wealth of clinical data supported through VISTA.

The SCD package accomplishes the following:

Uploads patient data to the National SCD Registry. The National Registry is used to provide VA-wide review of patient demographics, clinical aspects of disease, and resource utilization involved in providing care to patients.

Provides a variety of management reports for local use, including patients lost to follow-up, frequency of visits, and volume of lab tests and prescriptions per patient.

The ad hoc reporting capability provides the users with the ability to design their own custom reports.

Several functional measures/scales are provided with the package (CHART, FAM, DIENER, DUSOI) in addition to the FIM and the Self Report of Function. For multiple sclerosis patients, two measures/scales are available (the KURTZKE and the EDSS). Each of these scales/measures allows patient progress to be tracked over time.

Functional Description

Allows efficient entry of data into the local registry and outcome modules.

Provides a watch list of those patients currently not being seen at the medical center.

Tracks the utilization of resources used during treatment.

Extracts data on outpatient visits, inpatient activity, drugs, radiology, and lab tests specified by the SCD Expert Panel (EP) and the SCD Advisory Board.

Transports local data to the National SCD database at Austin, Texas.

Package Management

This package does not require special procedures for patient privacy other than that required by all V*IST*A packages. All patients contribute data to the VA's National SCD Registry.

Any research conducted using the National Registry, which requires absolute patient identification will be expected to secure consent from those patients.

Access to the package on a local level is restricted to users associated with the package. For the IRM Applications Coordinator, as well as the SCI Coordinator, the SCD Package Management Menu is restricted further to those holding the SPNL SCD MGT. For all users, access to reports with patient sensitive data is further restricted to those holding the SPNL SCD PTS key (see Package Operation for specific options).

Package Operation

The SCD package is comprised of the SCD Coordinator Menu to be given to the clinician or SCI Coordinator, and the SCD Package Management Menu for the IRM Applications Coordinator and the SCI Coordinator. Both of these menus are contained under the primary package menu, Spinal Cord Dysfunction.

SCD Coordinator Menu...

Registration and Health Care Information
[1]Clinical Information
Inpatient Rehabilitation Outcomes
Outpatient Rehabilitation Outcomes
Annual Evaluation Outcomes
Continuum of Care Outcomes
SCD Reports Menu...
Change your Division Assignment
Inquire to an Outcome
Edit Non-conforming Outcome

SCD Reports Menu...
SCI/SCD Admissions
Applications for Inpatient Care
SCI/SCD Discharges
Filtered Reports...
SCD Ad Hoc Reports...
Registration Ad Hoc Report
Self Report of Function Ad Hoc Report
FIM Ad Hoc Report
ASIA Ad Hoc Report
CHART Ad Hoc Report
FAM Ad Hoc Report
DIENER Ad Hoc Report
DUSOI Ad Hoc Report
Multiple Sclerosis Ad Hoc Report
Comprehensive Outcomes Ad Hoc Report
Basic Patient Information (132 Column)
Breakdown of Patients
CHART/FAM/DIENER/DUSOI Scores
Current Inpatients **Locked: SPNL SCD PTS**
Expanded Patient List (255 Column)
Patients with Future Appointments
Functional Independence Measures
Follow-Up (Last Annual Rehab Eval Received) **Locked: SPNL SCD PTS**
Follow-Up (Last Seen) **Locked: SPNL SCD PTS**
Health Summary **Locked: SPNL SCD PTS**
Inpatient/Outpatient Activity

[1] Patch SPN*2.0*19 - New options

Inpatient/Outpatient Activity (Specific)
New SCI/SCD Patients
Mailing Labels
Patient Listing
Patient Listing (Sort by State and County)
Registrant General Report
Registrant Injury Report
1Self Report of Function
Utilization Reports...
Laboratory Utilization
Laboratory Utilization (Specific)
Pharmacy Utilization
Pharmacy Utilization (Specific)
Radiology Utilization
Functional Status Scores
ICD9 Code Search
Print MS Help Text
MS (Kurtzke) Measures
MS Patient Listing
Patient Summary Report
Show Sites Where Patient has been Treated
Change your Division Assignment
Inquire to an Outcome
Edit Non-conforming Outcome

SCD Package Management Menu ... **Locked: SPNL SCD MGT**
Edit Site Parameters
Activate an SCD Registrant
Delete an Outcome Record
Delete Registry Record
Enter/Edit Etiology SYNONYM
Inactivate an SCD Registrant

Three of the above options (Laboratory Utilization, Pharmacy Utilization, Radiology Utilization) within the SCD Reports Menu were designed so that Laboratory, Pharmacy, and Radiology Service personnel can obtain statistical data without compromising patient confidentiality.

[1] Patch SPN*2.0*19 - New options

SCD Coordinator Functions

[1]The following options appear for selection.

```
REG     Registration and Health Care Information
CL      Clinical Information
IN      Inpatient Rehabilitation Outcomes
OUT     Outpatient Rehabilitation Outcomes
ANN     Annual Evaluation Outcomes
CON     Continuum of Care Outcomes
REP     SCD Reports Menu...
DIV     Change your Division Assignment
INQ     Inquire to an Outcome
OLD     Edit Non-conforming Outcome
```

Screen borders indicate dialogue that is on the computer screen. User input is indicated in bold print. Use the return key and/or the up, down, and side arrows when navigating through the screens. Enter one (?) or two (??) question marks to get field descriptions (two question marks will give a more detailed description). Use the up-arrow (^) to exit the screen at any prompt.

Note: The following screens are examples only and not meant to reflect real data.

[1] Patch SPN*2.0*19 - New options added and updated text.

Registration and Health Care Information

[1]The Registration and Health Care Information option is used to enter a new registrant into the SCD local registry or edit an existing registrant. Information consists of patient and administrative data describing the patient's dysfunction history and registration profile.

```
Select SCD Coordinator Menu Option:  Registration and Health Care Information

Select SCD (SPINAL CORD) REGISTRY PATIENT:  Chang,Mike
```

```
SCD REGISTRY   REGISTRATION SCREEN    DECEASED: MAY 14,2001     PAGE 1 OF 2
PATIENT: CHANG,MIKE                  SSN: 123123123    DOB: JUN 24,1931
VA SCI INDICATOR (MAS): PARAPLEGIA-NONTRAUMATIC    PHONE: (442) 512-1163
_____________________________________________________________________________

      VA SCI STATUS: PARAPLEGIA-TRAUMATIC        DATE OF ORIGINAL
REGISTRATION:
  SCI NETWORK (Y/N): YES                              JUL 16,2002
  REGISTRATION STATUS: EXPIRED                        DATE OF LAST REVIEW  |
                                                      AUG 20,2002@14:15
    CAUSE OF SCD (Etiology)            DATE OF ONSET     DESCRIBE OTHER
    VEHICULAR                          JUL 16,2002

SCI LEVEL: C05                               EXTENT OF SCI: COMPLETE
REMARKS:
                                             MS Subtype:
_____________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                      Press <PF1>H for help   Insert
```

[1] Patch SPN*2.0*19 – Updated text with revised displays.

```
SCD REGISTRY   HEALTH CARE SCREEN
PATIENT: CHANG,MIKE                                        PAGE 2 OF 2
SSN: 123123123                                        DOB: JUN 24,1931
_____________________________________________________________________________
AMOUNT VA IS USED: VA ONLY
PRIMARY CARE VA: SAN DIEGO HCS          ANNUAL REHAB VA: SAN DIEGO HCS
ADDITIONAL CARE RECEIVED AT VAMC:
NON-VA SOURCE OF CARE:
PRI CARE PROV: JONES,ALLISON              SCD-R COORD: GODBOLD,CHARLENE D
REFERRAL SOURCE: OTHER VA             REFERRAL VA: LONG BEACH HCS
INITIAL REHAB SITE: VA FACILITY WITH SCI CENTER  DATE OF D/C: OCT 2,2000
                DIVISION
                SAN DIEGO VAMC

ANNUAL REHAB EVAL:   OFFERED                RECEIVED                NEXT DUE
                    AUG 2,2002              AUG 3,2002             AUG 3,2003
_____________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                    Press <PF1>H for help    Insert
```

Clinical Information

The Clinical Information option allows you to enter findings from a clinical evaluation. (The information contained in this option is not required; therefore, use of it is entirely up to the medical center.) There are **two** screens associated with this module.

[1]Select SCD (SPINAL CORD) REGISTRY PATIENT: **CATT,FELIX**

```
CLINICAL REGISTRATION MODULE  PHYSICAL IMPAIRMENT SCREEN        PAGE 1 OF 2
PATIENT: CATT,FELIX                     SSN: 666770000     DOB: Aug 8, 1963
                                  VA SCI FLAG:
_____________________________________________________________________________

 MEMORY/THINKING AFFECTED (Y/N): NO        EYES AFFECTED (Y/N): NO
         ONE ARM AFFECTED (Y/N): NO     ONE LEG AFFECTED (Y/N): NO
       BOTH ARMS AFFECTED (Y/N): YES  BOTH LEGS AFFECTED (Y/N): YES
           BOWEL AFFECTED (Y/N): YES    BLADDER AFFECTED (Y/N): YES
 OTHER BODY PART AFFECTED (Y/N): NO             DESCRIBE OTHER:

          <<1-Full Useful Movement>>               <<1-Full Feeling>>
          <<2-Some Useful Movement>>               <<2-Some Feeling>>
          <<3-  No Useful Movement>>               <<3-  No Feeling>>
   EXTENT OF MOVEMENT: NO USEFUL MOVEMENT     EXTENT OF FEELING: NO FEELING

HAD AMPUTATION (Y/N)?: NO              HAD BRAIN INJURY (Y/N)?: NO
_____________________________________________________________________________
Exit     Save     Next Page    Refresh

Enter a command or '^' followed by a caption to jump to a specific field.


COMMAND: N                                    Press <PF1>H for help    Insert
```

```
CLINICAL REGISTRATION MODULE       CLINICAL CARE                PAGE 2 OF 2
PATIENT: CATT,FELIX                     SSN: 666770000     DOB: Aug 8, 1963
                                  VA SCI FLAG:
_____________________________________________________________________________
BWL CARE REMB: YES    DATE CERT.: APR 4,1999     PROVIDER: SMITH,L


ANNUAL REHAB EVAL:   OFFERED               RECEIVED             NEXT DUE
                  JAN 7,1997             JAN 8,1997          JAN 8,1998
                  DEC 20,1999            DEC 20,1999         DEC 19, 2000




_____________________________________________________________________________
Exit     Save     Refresh
```

[1] Patch SPN*2.0*19 January 2003 – Revised displays.

[1]Inpatient Rehabilitation Outcomes

This Care Type option controls viewing, editing, and creation of Outcomes records for inpatient rehabilitation episodes of care. An episode of care consists of a series of outcome records with the same care start date and the same care end date.

```
Select SCD (SPINAL CORD) REGISTRY PATIENT: DAVIDSON,HARLEY

                    Current INPATIENT Episode of Care

Patient: DAVIDSON,HARLEY    SSN: 496-01-6821
     Care Start Date: 11/01/2002
------------------------------------------------------------------------------
1) 11/01/2002  INPT START             ASIA
2) 11/01/2002  INPT START             FIM
------------------------------------------------------------------------------
  Select 1-2 of 2 to view/edit an outcome, '^' to exit, or
  <A> to Add a new outcome
  <P> to view/edit a Previous episode of care
     Selection: 1
```

```
                                       FIM                          PAGE 1 OF 4
PATIENT: DAVIDSON,HARLEY           SSN: 000-00-0001       DOB: May 25, 1919
_______________________________________________________________________________
         Care Start Date: 11/01/2002
                         Record Date: 11/01/2002

Score Type: INPT START                DISPOSITION: 6 SKILLED NURSING FACILITY

   <<IT IS RECOMMENDED CLINICIANS OBTAINING FIM DATA ARE FIM CREDENTIALED>>

                Select CLINICIAN: HENDRICKS,BERTHA R

        DAYS OF INTERRUPTED CARE:
_______________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                  Press <PF1>H for help    Insert
```

[1] Patch SPN*2.0*19 January 2003 – New option with revised displays.

```
                                        [1]FIM                      PAGE 2 OF  4 |
PATIENT: DAVIDSON,HARLEY                    SSN: 000000001   DOB: May 25, 1919
_____________________________________________________________________________
Record Date: NOV 1,2002
                                          Modified Independence -- Helper
  1=Total Assist (Subject 0%+)                 2=Maximal Assist (Subject=25%+)
  3=Moderate Assist (Subject=50%+)             4=Minimal Assist (Subject=75%+)
  5=Supervision
                         Independence -- No Helper
  6=Modified Independence (Device)      7=Complete Independence
(Timely,Safely)
                              SELF CARE
   EATING: TOTAL ASSISTANCE            DRESSING UPPER BODY: TOTAL ASSISTANCE
   GROOMING: TOTAL ASSISTANCE          DRESSING LOWER BODY: TOTAL ASSISTANCE
   BATHING: TOTAL ASSISTANCE              TOILETING: TOTAL ASSISTANCE

                            SPHINCTER CONTROL
BLADDER CONTROL: TOTAL ASSISTANCE       BOWEL CONTROL: TOTAL ASSISTANCE
_____________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                    Press <PF1>H for help    Insert
```

```
                                       FIM                       PAGE 3 OF 4
PATIENT: DAVIDSON,HARLEY             SSN: 000-00-0001    DOB: May 25, 1919
_____________________________________________________________________________
Record Date: NOV 1,2002
                      Modified Independence -- Helper
  1=Total Assist (Subject 0%+)          2=Maximal Assist (Subject=25%+)
 3=Moderate Assist (Subject=50%+)       4=Minimal Assist (Subject=75%+)
 5=Supervision
                         Independence -- No Helper
  6=Modified Independence (Device)   7=Complete Independence (Timely,Safely)
                              MOBILITY/TRANSFER
BED,CHAIR,WHEELCHAIR: TOTAL ASSISTANCE           TOILET: TOTAL ASSISTANCE
TUB,SHOWER: TOTAL ASSISTANCE

                                    LOCOMOTION
WALK/WHEELCHAIR METHOD: WHEELCHAIR  WALK/WHLCHAIR LEVEL: TOTAL ASSISTANCE
STAIRS: TOTAL ASSISTANCE
_____________________________________________________________________________
Exit     Save     Next Page     Refresh
```

[1] Patch SPN*2.0*19 January 2003 – New display.

```
                                    [1]FIM                              PAGE 4 OF 4  |
PATIENT: DAVIDSON,HARLEY                SSN: 000-00-0001  DOB: May 25, 1919
_____________________________________________________________________________
Record Date: NOV 1,2002
                        Modified Independence -- Helper
  1=Total Assist (Subject 0%+)            2=Maximal Assist (Subject=25%+)
  3=Moderate Assist (Subject=50%+)        4=Minimal Assist (Subject=75%+)
  5=Supervision
                         Independence -- No Helper
  6=Modified Independence (Device)        7=Complete Independence (Timely,
Safely)
                                  COMMUNICATION
   COMPREHENSION METHOD: BOTH         COMPREHENSION LEVEL: TOTAL ASSISTANCE
      EXPRESSION METHOD: BOTH           EXPRESSION LEVEL: TOTAL ASSISTANCE

                                SOCIAL COGNITION
SOCIAL INTERACTION: COMPLETE INDEPENDENCEPROBLEM SOLVING: COMPLETE
INDEPENDENCE
            MEMORY: COMPLETE INDEPENDENCE
_____________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.
```

```
=============================================================================
 Motor FIM Score:                    13.0
 Cognitive FIM Score:                23.0
 Total FIM Score:                    36.0
=============================================================================
```

[1] Patch SPN*2.0*19 January 2003 – New display.

[1]You have entered an INPT START or OUTPT START FIM for a patient with a C1-C3 spinal cord injury level and a motor complete ASIA Impairment Scale of A or B. Do you want to see a goal setting template you can copy and paste into a CPRS progress note? No// **Y** (Yes)

```
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Paralyzed Veterans of America (PVA).  Outcomes Following Traumatic Spinal
Cord Injury:  Clinical Practice Guideline for Health-Care Professionals.
Washington, DC:  Paralyzed Veterans of America, 1999.

 Press Return to continue// <RET>
```

	Bwl	Bldr	Trnsfr	Eat	DUB	DLB	Grmng	Bathe	WC Prp
Start	1	1	1	1	1	1	1	1	1
Median	1	1	1	1	1	1	1	1	1
Exp	1	1	1	1	1	1	1	1	6
Range	1	1	1	1	1	1	1	1	1-6
Goal									

The median FIM Motor Score for individuals with similar SCIs at one year following their injury is 13 (interquartile range 13-18). Other important considerations for individuals with motor complete C1-C3 tetraplegia include ventilator use and inability to clear secretions, equipment, or assistance to provide pressure relief and/or positioning, and communication equipment or assistance. Accessible public transportation or an attendant-operated van with lift and tie-downs is needed. The veteran should be able to instruct all aspects of care, but will need total assistance for homemaking.

[1] Patch SPN*2.0*19 January 2003 – New display and text.

[1]Outpatient Rehabilitation Outcomes

This Care Type option controls viewing, editing, and creation of Outcomes records for outpatient rehabilitation episodes of care. An episode of care consists of a series of outcomes records with the same care start date and the same care end date.

```
Select SCD (SPINAL CORD) REGISTRY PATIENT: DAVIDSON,HARLEY
```

```
Current OUTPATIENT Episode of Care

Patient: DAVIDSON,HARLEY    SSN: 000-00-0001
     Care Start Date: 09/04/2002
------------------------------------------------------------------------
1) 09/04/2002  OUTPT START            ASIA
2) 09/04/2002  OUTPT GOAL             FIM
3) 09/04/2002  OUTPT INTERIM          FIM
4) 09/10/2002  OUTPT INTERIM          DIENER
5) 09/11/2002  OUTPT INTERIM          DUSOI
6) 09/28/2002  OUTPT START            FIM
------------------------------------------------------------------------
  Select 1-6 of 6 to view/edit an outcome, '^' to exit, or
  <A> to Add a new outcome
  <P> to view/edit a Previous episode of care
```

[1] Patch SPN*2.0*19 January 2003 – New option and screen captures.

[1]Annual Evaluation Outcomes

This Care Type option controls viewing, editing, and creation of Outcomes records stemming from an annual evaluation. In this care type, therefore, the rehabilitation episode of care model is not utilized.

```
Select SCD (SPINAL CORD) REGISTRY PATIENT: DAVIDSON,HARLEY
```

```
                              Annual Evaluation


Patient: DAVIDSON,HARLEY    SSN: 000-00-0001
------------------------------------------------------------------------------
1) 01/02/2000  ASIA
2) 01/15/2000  Self Report of Function
3) 02/15/2000  FIM
4) 02/16/2000  ASIA
5) 02/19/2000  CHART
6) 02/21/2000  Self Report of Function
7) 02/21/2000  Self Report of Function
8) 03/01/2000  Self Report of Function
9) 03/15/2000  FIM
10) 03/19/2000 CHART
11) 03/21/2000 Self Report of Function
12) 04/01/2000 CHART
13) 04/15/2000 CHART
------------------------------------------------------------------------------
  Select 1-13 of 32 to view/edit an outcome, '^' to exit, or press
  <Return> to see the next group
  <A> to Add a new outcome

  Selection:
```

[1] Patch SPN*2.0*19 January 2003 – New option with revised displays.

[1]Continuum of Care Outcomes

This Care Type option controls viewing, editing, and creation of Outcomes records as part of a patient's continuum of care. A continuum of care outcome is not related to a discrete episode of inpatient or outpatient rehabilitation or an annual evaluation. In this care type, therefore, the episode of care model is not utilized.

```
Select SCD (SPINAL CORD) REGISTRY PATIENT: DAVIDSON,HARLEY
```

```
Continuum of Care

Patient: DAVIDSON,HARLEY    SSN: 000-00-0001
------------------------------------------------------------------------------
1) 03/29/1999  CHART
2) 04/15/1999  CHART
3) 05/30/1999  FIM
4) 06/13/1999  Self Report of Function
5) 07/31/1999  Self Report of Function
6) 08/15/1999  ASIA
7) 02/13/2000  CHART
8) 02/19/2000  ASIA
9) 03/15/2000  ASIA
10) 03/15/2000 CHART
11) 04/15/2000 CHART
12) 05/16/2000 ASIA
13) 06/15/2000 ASIA
------------------------------------------------------------------------------
  Select 1-13 of 29 to view/edit an outcome, '^' to exit, or press
  <Return> to see the next group
  <A> to Add a new outcome
```

[1] Patch SPN*2.0*19 January 2003 – New option with revised displays.

[1]Record Types

Within a given Care Type options (Inpatient Outcomes, Outpatient Outcomes, Annual Evaluation Outcomes, and Continuum of Care Outcomes), you may enter any of the seven different Record Types, which are:

1. Self Report of Function
2. FIM
3. ASIA
4. CHART
5. FAM
6. DIENER
7. DUSOI

Note: The Multiple Sclerosis type is displayed only if the patient has an etiology of MS.

The procedure for adding a new outcome record consists of selecting Care Type from the SCD Coordinator Menu, then selecting a patient, then pressing <A> to add a new outcome record, then answering the prompt for Score Type, selecting one of the following:

```
1     INPT START
2     INPT GOAL
3     INPT INTERIM
4     INPT REHAB FINISH
5     INPT FOLLOW/UP (END)
6     UNKNOWN

Select the score type you wish to enter/edit: 3
```

Note: If you are creating a brand new episode of care, the software will automatically insert a score type of INPT START or OUTPT START, whichever the case may be on the very first outcome. Thereafter, the user will be prompted for score type on each subsequent outcome.

Having selected #3 (INPT INTERIM), as an example, you will then be prompted to enter a Record Date for this outcome record.

```
Enter a New Record Date: 03/16/2000
```

Upon entering a Record Date, you will be presented with a ScreenMan screen for data entry.

In the following pages are examples of data entry sessions for each of the eight different Record Types.

[1] Patch SPN*2.0*19 January 2003 – New and updated Record Types.

[1]Self-Report of Function

```
                        SELF REPORT OF FUNCTION          PAGE 1 OF 3
PATIENT: CATT,FELIX                    SSN: 666770000    DOB: Aug 8, 1963
_____________________________________________________________________________
 Care Start Date: 03/05/2000    Care End Date: 04/28/2000
                             Record Date: 03/16/2000
Score Type: INPT INTERIM            DISPOSITION: 3 HOME ASSISTED
          RESPONDENT TYPE:

         <<1-Total Help or Never Do>>       <<2-Some Help>>
         <<3-Extra Time or Special Tool>>   <<4-No Extra Time or Help>>

 MOVE AROUND INSIDE HOUSE: TOTAL HELP OR              STAIRS: SOME HELP
    TRANSFER TO BED/CHAIR: TOTAL HELP OR    TRANSFER - TOILET: SOME HELP
    TRANSFER - TUB/SHOWER: EXTRA TIME OR             EATING: NO EXTRA TIME
                 GROOMING: SOME HELP                BATHING: SOME HELP
      DRESSING UPPER BODY: TOTAL HELP OR  DRESSING LOWER BODY: SOME HELP
                TOILETING: TOTAL HELP OR   BLADDER MANAGEMENT: SOME HELP
          BOWEL MANAGEMENT: EXTRA TIME OR
_____________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                    Press <PF1>H for help    Insert
```

[1] Patch SPN*2.0*19 January 2003– New Record Type with revised displays.

```
                        [1]SELF REPORT OF FUNCTION          PAGE 2 OF 3       |
PATIENT: CATT,FELIX                   SSN: 666770000         DOB: Aug 8, 1963
_____________________________________________________________________________
Record Date: MAR 16,2000

   <<1-Without Help>>          <<2-With Help>>          <<3-Unable>>


         GET TO PLACES OUTSIDE OF HOME: WITH HELP
                              SHOPPING: WITH HELP
        PLANNING AND COOKING OWN MEALS: WITH HELP
                       DOING HOUSEWORK: WITH HELP
                        HANDLING MONEY: WITHOUT HELP


_____________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: n                                  Press <PF1>H for help    Insert
```

```
                        SELF REPORT OF FUNCTION          PAGE 3 OF 3    |
PATIENT: CATT,FELIX                   SSN: 666770000         DOB: Aug 8, 1963
_____________________________________________________________________________
Record Date: MAR 16,2000
                  HELP DURING LAST 2 WEEKS: YES
   NUMBER OF HOURS OF HELP IN LAST 2 WEEKS: 30
  NUMBER OF HOURS OF HELP IN LAST 24 HOURS: 16

              <<1-Without Help>>      <<2-With Device>>
              <<3-Cannot Walk >>      <<4-Bedridden  >>

              METHOD AMBULATION (WALKING): CANNOT WALK

            <<1-Manual            >>          <<2-Motorized>>
            <<3-Does Not Use W/Chr>>          <<4-Bedridden>>

            METHOD AMBULATION (WHEELCHAIR): MOTORIZED
_____________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: S                                  Press <PF1>H for help    Insert|
```

```
=============================================================================
Self report of function total score: 26.0                                   |
=============================================================================
```

[1] Patch SPN*2.0*19 January 2003 – Updated report header.

[1]Functional Independence Measure (FIM)

```
                                  FIM                                PAGE 1 OF 4 |
PATIENT: CHANG,MIKE                      SSN: 123123123   DOB: Sep 17, 1900
_____________________________________________________________________________
        Care Start Date: 07/05/2001    Care End Date: 07/28/2001             |
                         Record Date: 07/09/2001                             |

Score Type: INPT INTERIM            DISPOSITION: 4 MILITARY BARRACKS ASSISTED
    <<Enter '??' to see pre-existing Clinician entries>>

    <<IT IS RECOMMENDED CLINICIANS OBTAINING FIM DATA ARE FIM CREDENTIALED>>

                Select CLINICIAN: ADAMS,JACK

            This list will include everyone who works at the hospital.
            Type in the last name to get a short list to choose from.


_____________________________________________________________________________
_
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: n                              Press <PF1>H for help    Insert
```

[1] Patch SPN*2.0*19 January 2003 – New Record Type with revised displays.

```
                                    [1]FIM                                PAGE 2 OF 4|
PATIENT: CHANG,MIKE                        SSN: 123123123       DOB: Sep 17,
1900
_____________________________________________________________________________
Record Date: FEB 25,2000
                        Modified Independence – No Helper
  1=Total Assist (Subject 0%+)          2=Maximal Assist (Subject=25%+)
  3=Moderate Assist (Subject=50%+)      4=Minimal Assist (Subject=75%+)
  5=Supervision
                         Independence -- No Helper
  6=Modified Independence (Device)      7=Complete Independence
(Timely,Safely)
                              SELF CARE
     EATING: MODERATE ASSISTANCE    DRESSING UPPER BODY: MODERATE ASSISTANCE
   GROOMING: MAXIMAL ASSISTANCE     DRESSING LOWER BODY: MODERATE ASSISTANCE
    BATHING: MODERATE ASSISTANCE              TOILETING: MAXIMAL ASSISTANCE

                           SPHINCTER CONTROL
BLADDER CONTROL: TOTAL ASSISTANCE       BOWEL CONTROL: TOTAL ASSISTANCE
_____________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.


COMMAND: N                                    Press <PF1>H for help    Insert
```

```
                                    FIM                                 PAGE 3 OF 4  |
PATIENT: CHANG,MIKE                        SSN: 123123123       DOB: Sep 17, 1900
_____________________________________________________________________________
Record Date: FEB 25,2000
                        Modified Independence -- Helper
  1=Total Assist (Subject 0%+)          2=Maximal Assist (Subject=25%+)
  3=Moderate Assist (Subject=50%+)      4=Minimal Assist (Subject=75%+)
  5=Supervision
                         Independence -- No Helper
  6=Modified Independence (Device)      7=Complete Independence
(Timely,Safely)
                            MOBILITY/TRANSFER
BED,CHAIR,WHEELCHAIR:                          TOILET: COMPLETE INDEPENDENCE
TUB,SHOWER: COMPLETE INDEPENDENCE

                                  LOCOMOTION
WALK/WHLCHAIR METHOD: WHEELCHAIR  WALK/WHLCHAIR LEVEL: COMPLETE INDEPENDENCE
STAIRS: COMPLETE INDEPENDENCE
_____________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: N                                    Press <PF1>H for help    Insert
```

[1] Patch SPN*2.0*19 January 2003 – Updated report header.

```
                                        [1]FIM                          PAGE 4 OF 4     |
PATIENT: CHANG,MIKE                      SSN: 123123123       DOB: Sep 17, 1900
_____________________________________________________________________________________
Record Date: FEB 25,2000
                        Modified Independence -- Helper
  1=Total Assist (Subject 0%+)          2=Maximal Assist (Subject=25%+)
  3=Moderate Assist (Subject=50%+)      4=Minimal Assist (Subject=75%+)
  5=Supervision
                         Independence -- No Helper
  6=Modified Independence (Device)      7=Complete Independence
(Timely,Safely)
                                 COMMUNICATION
 COMPREHENSION METHOD: AUDITORY  COMPREHENSION LEVEL: COMPLETE INDEPENDENCE
     EXPRESSION METHOD:             EXPRESSION LEVEL: COMPLETE INDEPENDENCE

                                SOCIAL COGNITION
SOCIAL INTERACTION: COMPLETE INDEPENDENCE     [2]PROBLEM SOLVING: COMPLETE INDEPENDENCE|
          MEMORY: COMPLETE INDEPENDENCE                                                 |
_____________________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND: S                                  Press <PF1>H for help    Insert
```

```
================================================================================
   Motor FIM Score:                    35.0
   Cognitive FIM Score:                35.0
   Total FIM Score:                    70.0
================================================================================
```

[1] Patch SPN*2.0*19 January 2003 – Updated report header.
[2] Patch SPN*2.0*19 January 2003 – Updated text.

[1]Craig Handicap Assessment and Reporting Technique (CHART)

```
  CRAIG HANDICAP ASSESSMENT AND REPORTING TECHNIQUE (CHART)   PAGE 1 OF 1
PATIENT: DAVIDSON,HARLEY            SSN: 000-00-0001   DOB: May 25, 1919
_____________________________________________________________________________

                        Record Date: 02/19/2000
                                     DISPOSITION: 1 HOME UNASSISTED

           CRAIG HANDICAP ASSESSMENT AND REPORTING TECHNIQUE (CHART)

                  PHYSICAL INDEPENDENCE (0-100): 78
                    MOBILITY (0-100): 76
                  OCCUPATION (0-100): 56
          SOCIAL INTERACTION (0-100): 76
    ECONOMIC SELF SUFFICIENCY (0-100): 78
       COGNITIVE INDEPENDENCE (0-100): 89       CHART TOTAL SCORE: 453
_____________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND; E                                Press <PF1>H for help    Insert
```

[1] Patch SPN*2.0*19 January 2003 – New Record Type with revised displays.

[1]Functional Assessment Measure (FAM)

```
            FUNCTIONAL ASSESSMENT MEASURE (FAM)                PAGE 1 OF 1
PATIENT: DAVIDSON,HARLEY       SSN: 000-00-0001          DOB: May 25, 1919
_____________________________________________________________________________

             Record Date: 04/15/2000
                                DISPOSITION: 4 MILITARY BARRACKS ASSISTED

 1 = Total Assistance    2 = Maximal Assistance  3 = Moderate Assistance
 4 = Minimal Assistance  5 = Supervision         6 = Modified Independence
 7 = Complete Independence

     EMPLOYABILITY: MINIMAL ASSISTANCE   AR TRANSFERS: MODERATE ASSISTANCE
  COMMUNITY ACCESS: MAXIMAL ASSISTANCE        READING: MODERATE ASSISTANCE
    SPEECH CLARITY: MODERATE ASSISTANCE       WRITING: MODERATE ASSISTANCE
  EMOTIONAL STATUS: MODERATE ASSISTANCE     ATTENTION: MODERATE ASSISTANCE
  SAFETY JUDGEMENT: MINIMAL ASSISTANCE    ORIENTATION: MINIMAL ASSISTANCE
 ADJ TO LIMITATION: MINIMAL ASSISTANCE     SWALLOWING: MINIMAL ASSISTANCE
_____________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                    Press <PF1>H for help    Insert
```

[1] Patch SPN*2.0*19 January 2003– New Record Type with revised displays.

[1]Diener's Satisfaction with Life Scale (DIENER)

```
        DIENER'S (1985) SATISFACTION WITH LIFE SCALE          PAGE 1 OF 1
PATIENT: DAVIDSON,HARLEY         SSN: 000-00-0001        DOB: May 25, 1919
_____________________________________________________________________________
         Care Start Date: 09/04/2002
                         Record Date: 09/10/2002

Score Type: OUTPT INTERIM        DISPOSITION: 4 MILITARY BARRACKS ASSISTED

                  DIENER'S (1985) SATISFACTION WITH LIFE SCALE

                       DIENER COMPOSITE SCORE (0-35): 22

_____________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                    Press <PF1>H for help    Insert
```

[1] Patch SPN*2.0*19 January 2003 – New Record Type with revised displays.

[1]Duke University Severity of Illness Index (DUSOI)

```
     DUKE UNIVERSITY SEVERITY OF ILLNESS INDEX (DUSOI)         PAGE 1 OF 1
PATIENT: DAVIDSON,HARLEY          SSN: 000-00-0001       DOB: May 25, 1919
_____________________________________________________________________________

         Care Start Date: 09/04/2002
                         Record Date: 09/11/2002

Score Type: OUTPT INTERIM          DISPOSITION: 5 ASSISTED LIVING FACILITY

                DUKE UNIVERSITY SEVERITY OF ILLNESS INDEX (DUSOI)

                        DUSOI COMPOSITE SCORE (0-100): 99
_____________________________________________________________________________
Exit     Save     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                    Press <PF1>H for help  Insert
```

[1] Patch SPN*2.0*19 January 2003 – New Record Type with revised displays.

[1]American Spinal Injury Association (ASIA)

```
                                    ASIA                              PAGE 1 OF 2
PATIENT: TEST,PATIENT B                 SSN: 000000796    DOB: Nov 07, 1955
_____________________________________________________________________________
       Care Start Date: 07/05/2001    Care End Date: 07/28/2001             |
                        Record Date: 07/07/2001                              |

Score Type: INPT START           DISPOSITION: 4 MILITARY BARRACKS ASSISTED  |

  ASIA IMPAIRMENT SCALE: C           ASIA COMPLETE/INCOMPLETE: INCOMPLETE

      TOTAL MOTOR SCORE: 65             TOTAL PIN PRICK SCORE: 65

TOTAL LIGHT TOUCH SCORE: 45          ASIA HIGHEST NEURO LEVEL: T02

_____________________________________________________________________________
Exit     Save     Next Page     Refresh

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                        Press <PF1>H for help
Insert
```

```
                                  ASIA                              PAGE 2 OF 2
PATIENT: TEST,PATIENT B                 SSN: 000046184    DOB: Nov 07, 1955
_____________________________________________________________________________

Record Date: APR 7,1998

      NEUROLEVEL-SENSORY RIGHT: T02         NEUROLEVEL-SENSORY LEFT: T02

        NEUROLEVEL-MOTOR RIGHT: L04           NEUROLEVEL-MOTOR LEFT: L04


PARTIAL PRESERVATION-SENSORY R: L04  PARTIAL PRESERVATION-SENSORY L: L04

  PARTIAL PRESERVATION-MOTOR R: L04    PARTIAL PRESERVATION-MOTOR L: L04


_____________________________________________________________________________


COMMAND:                Press <PF1>H for help    Insert
```

[1] Patch SPN*2.0*19 January 2003 – Record Type with revised displays.

[1]Multiple Sclerosis

```
                        MS Functional Status Module
PATIENT: DAVIDSON,HARLEY                  SSN: 000000001    DOB: May 25, 1919
_____________________________________________________________________________
         Care Start Date: 07/05/2001    Care End Date: 07/28/2001           |
                         Record Date: 07/16/2001                             |

Score Type: INPT INTERIM            DISPOSITION: 1 HOME UNASSISTED

               Select one of the following:

                  1)  Kurtzke Functional Systems Scale (FSS)
                  2)  Kurtzke Expanded Disability Status Scale (EDSS)

               Select the type of record you wish to enter/edit: 1



_____________________________________________________________________________

COMMAND:                                      Press <PF1>H for help    Insert
```

[1]Patch SPN*2.0*19 January 2003– Record Type with revised displays.

KURTZKE Functional System Scale (FSS)

```
                KURTZKE FUNCTIONAL SYSTEM SCALE (FSS)     PAGE 1 OF 1
PATIENT: DAVIDSON,HARLEY        SSN: 000000001      DOB: May 25, 1919
_____________________________________________________________________________
Record Date: JUL 16,2001

                          ?? for options

  PYRAMIDAL: 1 Abnormal signs without disability
 BRAINSTEM: 2 Moderate nystagmus or other mild disability
   SENSORY: 0 Normal
  CEREBRAL: 0 Normal
CEREBELLAR: 3 Moderate trunk or limb ataxia (interferes with function)
 BWL/BLDDR: 4 Constant cath (and constant use of measure to evacuate stool)
    VISUAL: 0 Normal
     OTHER:
 _____________________________________________________________________

COMMAND:                                  Press <PF1>H for help    Insert
```

KURTZKE Expanded Disability Status Scale (EDSS)

```
           KURTZKE EXPANDED DISABILITY STATUS SCALE (EDSS)      PAGE 1 OF 1
PATIENT: DAVIDSON,HARLEY                  SSN: 000000001   DOB: May 25, 1919
_____________________________________________________________________________
Record Date: JUN 28,2000

                              ?? for options

                             99.9 for Unknown



EDSS score:
 4.5  1 FS grade 4; walk without aid or rest 300 m
_____________________________________________________________________________
Exit     Save     Refres

Enter a command or '^' followed by a caption to jump to a specific field.

COMMAND:                                      Press <PF1>H for help    Insert
```

SCD Reports Menu

The SCD Reports Menu groups together the various reports and forms that can be printed with the SCD package.

SCD Reports Menu ...

- SCI/SCD Admissions
- Applications for Inpatient Care
- SCI/SCD Discharges
- Filtered Reports...
  - SCD Ad Hoc Reports...
    - [1]Registration Ad Hoc Report
    - Self Report of Function Ad Hoc Report
    - FIM Ad Hoc Report
    - ASIA Ad Hoc Report
    - CHART Ad Hoc Report
    - FAM Ad Hoc Report
    - DIENER Ad Hoc Report
    - DUSOI Ad Hoc Report
    - Multiple Sclerosis Ad Hoc Report
    - Comprehensive Outcomes Ad Hoc Report
  - Basic Patient Information (132 Column)
  - Breakdown of Patients
  - CHART/FAM/DIENER/DUSOI Scores
  - Current Inpatients
  - Expanded Patient List (255 Column)
  - Patients with Future Appointments
  - Functional Independence Measures
  - Follow-Up (Last Annual Rehab Eval Received)
  - Follow-Up (Last Seen)
  - Health Summary
  - Inpatient/Outpatient Activity
  - Inpatient/Outpatient Activity (Specific)
  - New SCI/SCD Patients
  - Mailing Labels
  - Patient Listing
  - Patient Listing (Sort by State and County)
  - Registrant General Report
  - Registrant Injury Report
  - Self Report of Function
  - Utilization Reports...
    - Laboratory Utilization
    - Laboratory Utilization (Specific)
    - Pharmacy Utilization
    - Pharmacy Utilization (Specific)
    - Radiology Utilization
- Functional Status Scores

[1] Patch SPN*2.0*19 January 2003 – New options.

ICD9 Code Search
Print MS Help Text{XE " Print MS Help Text"}
MS (Kurtzke) Measures
MS Patient Listing
Patient Summary Report
Show Sites Where Patient has been Treated

SCD Reports Menu...

SCI/SCD Admissions

This report provides a list of SCD patients who have been admitted within a user-specified date range. The list consists of admitted patients who are either in the SCD Registry or who have been marked as SCI in the Patient file (i.e., field 57.4, "SPINAL CORD INJURY", has been populated). This option will also highlight patients that are not in the Registry.

```
Select SCD Reports Menu Option: ADM  SCI/SCD Admissions
   Enter START Date: 090100  (SEP 01, 2000)
   Enter END Date: T  (SEP 28, 2000)
Select DEVICE: HOME//   [Enter a device name]
```

```
Sep 28, 2000@15:21:48                                              Page: 1

                                                  SCD Admissions
                                            From 09/01/2000 to 09/28/2000

Date Admitted           Ward     Room-Bed         Diagnosis Codes
-------------------------------------------------------------------------------
Patient: BURKE,XXXXXX   SSN: 1983NNNNN         SCI: QUADRIPLEGIA-TRAUMATIC
 Etiology: VEHICULAR    Registration Date: 08/07/2000
09/12/2000@13:31:19     1ESCI   1E-B1109-02    BRONCHITIS NOS
                                               TRACHEA/BRONCHUS DIS NEC
                                               QUADRIPLEGIA C5-C7, COMPL
                                               LATE EFF SPINAL CORD INJ
                                               LATE EFF MOTOR VEHIC ACC

Patient: CASTRO,XXXXX   SSN: 5718NNNNN         SCI: PARAPLEGIA-TRAUMATIC
09/07/2000@16:29:20     5ENSGY  5E-B5217-05    COMP-OTH INT ORTHO DEVICE
                                               PARAPLEGIA NOS
                                               SPINAL CORD DISEASE NOS
                                               LATE EFF ACCIDENTAL FALL
***NOT IN THE REGISTRY!***
```

SCD Reports Menu...

Applications for Inpatient Care

This option produces reports on applications for inpatient care during a specific range of dates in your local SCD registry. Enter start date and end date as shown below.

```
Report Filter:
   Enter START Date: 1/93  (JAN 1993)
   Enter END Date: T  (NOV 15, 1996)
Select DEVICE: HOME//  [Enter a device name]
```

```
May 10, 2000@09:03:59                                          Page: 1
                              Applications for Inpatient Care
                               From: 1/0/93 to: 5/10/00

                                      Date of
Patient                               Dispos.   Disposition
-------------------------------------------------------------------------
BLFKN,IXYLAI A (B4200)                2/29/96   SCHEDULE FUTURE APPOINTMENT
                               TYPE OF BENEFIT: HOSPITAL

BLFLATX,CXTH D (B7473)                5/27/98   SCHEDULE FUTURE APPOINTMENT
                               TYPE OF BENEFIT: HOSPITAL

BLJXY,UXYLAI A (B4684)                2/27/94   SCHEDULE FUTURE APPOINTMENT
                               TYPE OF BENEFIT: HOSPITAL

BLSUHM,KXKKN L (B3259)                12/29/97  SCHEDULE FUTURE APPOINTMENT
                               TYPE OF BENEFIT: HOSPITAL
```

SCD Reports Menu...

SCI/SCD Discharges

This option produces reports on discharged patients for a given date range displaying discharge dates, discharge location, diagnosis codes, a frequency table of discharge destination, and other information as shown in the dialogue below.

```
Report Filter:
   Enter START Date: 11/1/94  (NOV 01, 1994)
   Enter END Date: 11/1/96  (NOV 01, 1996)
Select DEVICE: HOME// [Enter a device name]
```

```
Nov 05, 1996@08:09:11                                          Page: 1

                          SCD/SCI Discharge Patients
                          From: 11/1/94 to: 11/1/96

Date D/C   LOS  D/C Location                    Diagnosis Codes
-------------------------------------------------------------------------

  Patient: BOY,BILLY                SSN: 263638949    SCI: NOT APPLICABLE
  Etiology: FALL
11/17/94   1    3 SOUTH                          MALIGNANT HYPERTENSION
                                                 ANXIETY STATE NEC

Enter RETURN to continue or '^' to exit: <RET>
```

```
Nov 05, 1996@08:09:30                                                Page: 2

                          SCD/SCI Discharge Patients
                          From: 11/1/94 to: 11/1/96

Date D/C   LOS  D/C Location                      Diagnosis Codes
------------------------------------------------------------------------------

  Patient: GIBSON,MEL                 SSN: 284627548    SCI:
  Etiology: MULTIPLE SCLEROSIS                Registration Date: 11/2/95
1/14/95    1    37 NORTH                          CRB THROMB W/O CRB INF


  Patient: PATIENT,NUMBER ONE         SSN: 555123456    SCI: NOT APPLICABLE
  Etiology: FALL                              Registration Date: 3/13/96
2/1/95     1    37 NORTH

               3 Patients have been processed.
```

```
Nov 05, 1996@08:09:30                                                Page: 1

                          SCD/SCI Discharges Patients
                    Frequency Table of Discharge Destination

         Facility                                Station #    Total
        ------------------------------------------------------------------
        | HINES                                 | 578        | 1         |
        ------------------------------------------------------------------
        | MILWAUKEE                             | 695        | 1         |
        ------------------------------------------------------------------
Enter RETURN to continue or '^' to exit:  <RET>
```

SCD Reports Menu...

Filtered Reports

Using Filtered Reports

When you use Filtered Reports, you can choose to eliminate certain types of records you don't want in your report or you can choose to not use filters which means all records will appear in your report.

```
Do you wish to use the SCD filters with the reports? YES// <RET>
```

- If you answer NO to the above prompt, no filters will be applied to your reports except for those few that are specific to some of the reports. Note the individual reports in the following chapters to see those filters that do apply.
- If you answer YES to the above prompt, the filters can be applied to select or all reports you choose to print under the Filtered Reports menu.

Up Front Filters
If you answer YES to use the SCD filters and you plan to print more than one report, determine the following:
Filter all the reports the same for SCI Network Status and/or Registration Status? If you want to filter all reports the same, make those selections at this point and for every report you choose to print, the filters will apply.

Note: These filters will apply to <u>all</u> reports you choose before exiting the Filtered Reports menu.

```
Up Front Filters:
SCI Network Status
      A) SCI Network
      B) Non-SCI Network
      C) Both A and B
Select SCI Network: A  SCI Network
    Registration Status
      A) SCD-Currently served
      B) SCD-Not Currently served
      C) Both A&B
      D) Not SCD
      E) Expired
Select Registration Status: A  SCD-Currently served
```

In the above example, you would get only those records in all the reports you print that are designated as SCI Network (patients followed within the SCI network) and SCD-Currently Served (true SCD patients who are seen at the facility on a continuing basis) in your report.

Do not filter all the reports the same way? If you do not want to filter all reports the same way, bypass the Up Front Filters by pressing the <RET> key for each. By doing this, the Up Front Filters will appear for selection after each report you choose to print. You may decide then which filters you want to apply to each report.

```
Up Front Filters:
SCI Network Status
      A) SCI Network
      B) Non-SCI Network
      C) Both A and B
Select SCI Network: <RET>
    Registration Status
      A) SCD-Currently served
      B) SCD-Not Currently served
      C) Both A&B
      D) Not SCD
      E) Expired
Select Registration Status: <RET>
```

Filterable Reports
You can apply the Up Front Filters to the following reports. This menu appears after either selecting Up Front Filters or bypassing them.

```
   ADH    SCD Ad Hoc Reports ...
   BPI    Basic Patient Information (132 Column)
   BRK    Breakdown of Patients
[1] CFDD   CHART/FAM/DIENER/DUSOI Scores
   CI     Current Inpatients
   EPL    Expanded Patient List (255 Column)
   FA     Patients with Future Appointments
   FIM    Functional Independence Measures
   FULE   Follow-Up (Last Annual Rehab Eval Received)
   FULS   Follow-Up (Last Seen)
   HS     Health Summary
   IOA    Inpatient/Outpatient Activity
   IOAS   Inpatient/Outpatient Activity (Specific)
   LNS    New SCI/SCD Patients
   ML     Mailing Labels
   PL     Patient Listing
   PLSC   Patient Listing (Sort by State and County)
   RGR    Registrant General Report
   RIR    Registrant Injury Report
   SELF   Self Report of Function
   UTL    Utilization Reports...
```

[1] Patch SPN*2.0*19 January 2003 – New options.

Automatic Filters
Once you select a report, you may also be given the opportunity to use Automatic Filters and User Selectable Filters. Automatic Filters and User Selectable Filters are not available with every report. Automatic Filters allow you to select records of patients by the cause of the injury and/or the extent of injury:

```
Automatic Filters:
    Cause of Injury:
      T) Traumatic
      N) Non-traumatic
      B) Both Traumatic and Non-traumatic
      U) Unknown
  Select Cause:
    Extent of Injury:
      P) Paraplegia
      Q) Quadriplegia
      B) Both
  Select Injury:
```

User Selectable Filters
User Selectable Filters, also not available with every report, allow you to narrow your record selection even further.

```
Choose from:
   ADDITIONAL CARE VA
   AGE
   ANNUAL REHAB EVAL NEXT DUE
   ANNUAL REHAB VA
   COUNTY
   DIAGNOSIS
   DIVISION
   FEE BASIS
   GEOGRAPHICAL AREA
   HOURS OF HELP NEEDED
   IMPAIRMENTS
   IN/OUT PATIENT VISIT
   MEDICATIONS
   PRIMARY CARE VA
   PROSTHETICS
   RACE
   REGISTRATION STATUS
   SCI LEVEL
   SERVICE CONNECTION
   SEX
   TOTAL FIMS CHANGE OVER TIME
   VITAL STATUS
   WALK / WHEELCHAIR
```

Note: You cannot use more than **three** User Selectable Filters for one report.

Additional Care VA: This field was added for the benefit of merged sites. A site can retrieve its own patients via this filter. Answer with INSTITUTION NUMBER, NAME, STATION NUMBER, OFFICIAL VA NAME, or CURRENT LOCATION.

```
Enter a Facility from the list shown.

Additional Care VA: SAN DIEGO
     1   SAN DIEGO COUMADIN LAB    CA                      664.1
     2   SAN DIEGO, CA             CA               VAMC   664
     3   SAN DIEGO-RO              CA                      377
CHOOSE 1-3: 2  SAN DIEGO, CA       CA               VAMC   664
Sequence: 1
          ADDITIONAL CARE VA=SAN DIEGO, CA
```

Age: If you want to limit your report to patients within a specific age group, use the Age filter. You might want a report that breaks out the data in age ranges. Enter the beginning and ending age for the entire range and the ages will be shown in five-year increments.

```
Select Filter: AGE
Age range start value: 35
Age range end value:   44
Sequence: 1
          BEGINNING AGE=35
          ENDING AGE=44
```

Annual Rehab Eval Next Due : If you want to limit your report to patients who are due for their annual rehab evaluation, then use the Annual Rehab Eval Next Due filter. This would be particularly handy for printing mailing addresses for veterans due for evaluation.

```
Select Filter:    ANNUAL REHAB EVAL NEXT DUE
Beginning date: 1/1/2000  (JAN 01, 2000)
Ending date:   1/31/2000  (JAN 31, 2000)
Sequence: 1
          BEGINNING DATE=JAN 1,2000
          ENDING DATE=JAN 31,2000
```

Annual Rehab VA: This field was added mainly for the benefit of merged sites. A site can retrieve its own patients via this filter. Answer with INSTITUTION NUMBER, NAME, STATION NUMBER, OFFICAL VA NAME, or CURRENT LOCATION.

```
Enter a Facility from the list shown.

Annual Rehab VA Facility: San Diego
     1   SAN DIEGO COUMADIN LAB    CA                      664.1
     2   SAN DIEGO, CA             CA               VAMC   664
     3   SAN DIEGO-RO              CA                      377
CHOOSE 1-3: 2  SAN DIEGO, CA       CA               VAMC   664
Sequence: 1
          ANNUAL REHAB VA=SAN DIEGO, CA
```

County: If you want to limit the records to a specific county, use the County filter. This might be useful when printing mailing labels or reviewing patient demographics.

```
Select Filter: COUNTY
Select STATE NAME: ILLINOIS
Select COUNTY: COOK       031
Sequence: 1
                  COUNTY=COOK
                  STATE=ILLINOIS
```

Diagnosis: If you want to limit your report to patients with a specific diagnosis, use the Diagnosis filter.

```
Select Filter: DIAGNOSIS
SCD Diagnosis (etiology): ??

Choose from:
   1      SPORTS ACTIVITY     TRAUMATIC CAUSE
   2      ACT OF VIOLENCE     TRAUMATIC CAUSE
   3      VEHICULAR     TRAUMATIC CAUSE
   4      FALL     TRAUMATIC CAUSE
   5      INFECTION OR ABSCESS     NON-TRAUMATIC CAUSE
   6      OTHER - TRAUMATIC     TRAUMATIC CAUSE
   7      MOTOR NEURON DISEASE     NON-TRAUMATIC CAUSE
   8      MULTIPLE SCLEROSIS     NON-TRAUMATIC CAUSE
   9      TUMOR     NON-TRAUMATIC CAUSE
   10     OTHER     UNKNOWN
   11     OTHER - DISEASE     NON-TRAUMATIC CAUSE
   12     POLIOMYELITIS     NON-TRAUMATIC CAUSE
   13     UNKNOWN     NON-TRAUMATIC CAUSE
   14     UNKNOWN     TRAUMATIC CAUSE
   15     SYRINGOMYELIA     NON-TRAUMATIC CAUSE
   16     ARTHRITIC DISEASE OF THE SPINE     NON-TRAUMATIC CAUSE

Enter an etiology from the list shown.

SCD Diagnosis (etiology): 1  SPORTS ACTIVITY     TRAUMATIC CAUSE
         ...OK? Yes// <RET>  (Yes)
Sequence: 1
          ETIOLOGY=SPORTS ACTIVITY
```

Division: This field was added mainly for the benefit of merged sites. A site can retrieve its own patients via this filter. Answer with MEDICAL CENTER DIVISION NUM, NAME, FACILITY NUMBER, or TREATING SPECIALTY.

```
Select Filter: DIVISION
Division: Choose from: Enter a Division from the list shown.

1            SAN DIEGO VAMC     664
4            MISSION VALLEY VAOPC     664BY
5            EL CENTRO VAOPC     664GA
6            VISTA CBOC     664GB
7            CHULA VISTA CBOC     664GC
8            ESCONDIDO CBOC     664GD
Enter Division: 1
```

Fee Basis: If you want to see only Fee Basis patients in your report, use the Fee Basis Filter.

```
Select Filter: FEE BASIS
Beginning date: 1/1/99  (JAN 01, 1999)
Ending date:   1/1/2000  (JAN 01, 2000)
Sequence: 1
          BEGINNING DATE=JAN 1,1999
          ENDING DATE=JAN 1,2000
```

Geographical Area: If you want a report of patients located within a specific zip code area, use the Geographical Area filter.

```
Select Filter: GEOGRAPHICAL AREA
Zip code range start value: 60612
Zip code range end value:   60613
Sequence: 1
          BEGINNING ZIP=60612
          ENDING ZIP=60613
```

Hours of Help Needed: If you want a report of patients requiring a certain amount of help, use the Hours of Help Needed filter.

```
Select Filter: HOURS OF HELP NEEDED
Hours of help needed start value: 100
Hours of help needed end value:   224
Beginning date: T-14  (DEC 08, 1999)
Ending date:   T  (DEC 22, 1999)
Sequence: 1
          BEGINNING # HRS HELP=100
          ENDING # HRS HELP=224
Sequence: 1.1
          BEGINNING DATE=DEC 8,1999
          ENDING DATE=DEC 22,1999
```

Impairments: If you want a report showing patients with a certain impairment level, use the Impairments filter. Note: You may enter a range of impairments or discrete impairments for your report.

```
Select Filter: IMPAIRMENTS
Impairments: ??

  0 - DON'T KNOW
  1 - NONE
  2 - INCOMPLETE MOTOR
  3 - INCOMPLETE SENSORY
  4 - COMPLETE MOTOR
  5 - COMPLETE SENSORY
  6 - INCOMPLETE SENSORY AND MOTOR
  7 - COMPLETE SENSORY AND INCOMPLETE MOTOR
  8 - INCOMPLETE SENSORY AND COMPLETE MOTOR

You may enter a range of impairments '1-3',
discrete impairments '1,3,5', or any
combination of these '1-3,5,7'.
Choose any combination of impairments by number

Impairments: 3,5
Sequence: 1
          COMPLETENESS OF INJURY=INCOMPLETE SENSORY; COMPLETE
SENSORY
```

In/Out Patient Visit: If you want to restrict your report to inpatients or outpatients, use the In/Out Patient Visit filter.

```
Select Filter: IN/OUT PATIENT VISIT
Type of Visit: ??

Enter 'I', 'O', or 'B'.

     Select one of the following:

          I         INPATIENT
          O         OUTPATIENT
          B         BOTH INPATIENT & OUTPATIENT

Type of Visit: INPATIENT
Beginning date: T-14  (DEC 08, 1999)
Ending date:    T  (DEC 22, 1999)
Sequence: 1
          VISIT TYPE=INPATIENT
Sequence: 1.2
          BEGINNING DATE=DEC 8,1999
          ENDING DATE=DEC 22,1999
```

Medications: If you want a report of patients on specific types of medications, use the Medications filter. More than one type of medication can be selected.

```
Select Filter: MEDICATIONS
Select VA DRUG CLASS CODE: 84  CN400
   ANTICONVULSANTS
         ...OK? Yes// <RET>  (Yes)

Select VA DRUG CLASS CODE: <RET>

Enter the date range to search for the selected Medications
Beginning date: T-14  (DEC 08, 1999)
Ending date:    T  (DEC 22, 1999)
Sequence: 1
                    DRUG CLASS=CN400
Sequence: 1.1
          BEGINNING DATE=DEC 8,1999
          ENDING DATE=DEC 22,1999
```

Primary Care VA: This field was added mainly for the benefit of merged sites. A site can retrieve its own patients via this filter. Answer with INSTITUTION NUMBER, or NAME, STATION NUMBER, OFFICAL VA NAME, or CURRENT LOCATION.

```
Primary Care VA: SAN DIEGO
     1   SAN DIEGO COUMADIN LAB    CA                        664.1
     2   SAN DIEGO, CA             CA             VAMC       664
     3   SAN DIEGO-RO              CA                        377
CHOOSE 1-3: 2  SAN DIEGO, CA       CA             VAMC       664
Sequence: 1
          PRIMARY CARE VA=SAN DIEGO, CA
```

Prosthetics: If you want a report of patients using specific prosthetics, use the Prosthetics filter. You may select any number you need for your report.

```
Select Filter: PROSTHETICS
Select PROS AMIS CODES: ??

Choose from:
   1         01 A     AID FOR BLIND     ADMINISTRATIVE ISSUE
   2         01 B     SPEC BLIND EQP OVER $2,000
ADMINISTRATIVE ISSUE
   3         04 A     ART LEG,IPOP     ADMINISTRATIVE ISSUE
   4         04 B     ART LEG,TEM     ADMINISTRATIVE ISSUE

Select PROS AMIS CODES: 75  08 E     BRACES, ALL OTHER
ORTHOTIC LAB
         ...OK? Yes// <RET>  (Yes)
   BRACES, ALL OTHER
Another: 71  08 A     BRACES, ANKLE     ORTHOTIC LAB
         ...OK? Yes// <RET>  (Yes)
   BRACES, ANKLE
Another: 72  08 B     BRACES, CERVICAL, CUSTOM-MADE     ORTHOTIC
LAB
```

```
         ...OK? Yes// <RET>  (Yes)
   BRACES, CERVICAL, CUSTOM-MADE
Another: 73  08 C     BRACES, LEG, A/K     ORTHOTIC LAB
         ...OK? Yes// <RET>  (Yes)
   BRACES, LEG, A/K
Another: 74  08 D     BRACES, SPINAL     ORTHOTIC LAB
         ...OK? Yes// <RET>  (Yes)
   BRACES, SPINAL
Another: <RET>
Sequence: 1
                    PROSTH=BRACES, ANKLE
                    PROSTH=BRACES, CERVICAL, CUSTOM-MADE
                    PROSTH=BRACES, LEG, A/K
                    PROSTH=BRACES, SPINAL
                    PROSTH=BRACES, ALL OTHER
```

Race: If you want a report on patients by race, use the Race filter.

```
Select Filter: RACE
Patient race: ??

Choose from:
   1            AMERICAN INDIAN OR ALASKA NATIVE     3
   2            ASIAN OR PACIFIC ISLANDER     5
   3            BLACK, NOT OF HISPANIC ORIGIN     4
   4            HISPANIC, BLACK     2
   5            HISPANIC, WHITE     1
   6            UNKNOWN     7
   7            WHITE, NOT OF HISPANIC ORIGIN     6

Enter a race from the list shown.
Patient race: AMERICAN       3
Sequence: 1
          RACE= AMERICAN
```

Registration Status: If you want your report on patients in a particular registration status, use the Registration Status filter.

```
Select Filter: REGISTRATION STATUS
Registration status: ?

Enter the desired registration status A-E.

     Select one of the following:

          A         SCD-Currently served
          B         SCD-Not Currently served
          C         Both A&B
          D         Not SCD
          E         Expired

Registration status: D  NOT SCD
Sequence: 1
          REGISTRATION STATUS=NOT SCD
```

SCI Level: If you want a report on patients within a level of injury range, use the SCI Level filter.

```
Select Filter:    SCI LEVEL
NLOI start value: ??

Choose from:
   1            C01     CERVICAL     01
   2            C02     CERVICAL     02
   3            C03     CERVICAL     03
   4            C04     CERVICAL     04
   5            C05     CERVICAL     05
   6            C06     CERVICAL     06
   7            C07     CERVICAL     07
   8            C08     CERVICAL     08
   9            T01     THORACIC     01
   10           T02     THORACIC     02
   11           T03     THORACIC     03
   12           T04     THORACIC     04
   13           T05     THORACIC     05
   14           T06     THORACIC     06
   15           T07     THORACIC     07
   16           T08     THORACIC     08
   17           T09     THORACIC     09
   18           T10     THORACIC     10
   19           T11     THORACIC     11
   20           T12     THORACIC     12
   21           L01     LUMBAR       01
   22           L02     LUMBAR       02
   23           L03     LUMBAR       03
   24           L04     LUMBAR       04
   25           L05     LUMBAR       05
   26           S01     SACRAL       01
   27           S02     SACRAL       02
   28           S03     SACRAL       03
   29           S04     SACRAL       04
   30           S05     SACRAL       05
   31           UNK     UNKNOWN


Enter the top-most vertebral level desired.

SCI Level start value: 9  T01     THORACIC     01
         ...OK? Yes// <RET>  (Yes)

SCI Level end value:   20  T12     THORACIC     12
         ...OK? Yes// <RET>  (Yes)

Sequence: 1
          BEGINNING SCI LEVEL=T01
          ENDING SCI LEVEL=T12
```

Service Connection: If you want a report of patients by their service connection, use the Service Connection filter.

```
Select Filter: SERVICE CONNECTION
Service connected percentage start value: 50
Service connected percentage end value:   100
Sequence: 1
          BEGINNING SVC CONNECTED %=50
          ENDING SVC CONNECTED %=100
```

Sex: If you want a report of either Male or Female patients, use the Sex filter.

```
Select Filter: SEX
Patient sex: FEMALE
Sequence: 1
          SEX=FEMALE
Select Filter:
```

Total FIMS Change Over Time : If you want a report that shows the FIMS change for a delta value range, use the Total FIMS Change Over Time filter.

```
Select Filter: TOTAL FIMS CHANGE OVER TIME
Record Type: ?

Enter 1 for [1]Self Report of Function, or 2 for FIM

     Select one of the following:

          1         Self Report of Function
          2         FIM

Record Type: 2  FIM
Beginning delta value: ?

Enter a number from -108 to 108.

Beginning delta value: 0
Ending delta value:   108
Beginning date: T-100  (SEP 18, 1999)
Ending date:   T  (DEC 27, 1999)
Sequence: 1
          RECORD TYPE=FIM
Sequence: 1.1
          BEGINNING DELTA VALUE=0
          ENDING DELTA VALUE=108
Sequence: 1.2
          BEGINNING DATE=SEP 18,1999
          ENDING DATE=DEC 27,1999
```

[1] Patch SPN*2.0*19 January 2003 – New Record Types.

Vital Status: If you want a report of patients within a specific vital status (Alive or Dead), use the Vital Status filter.

```
Select Filter: VITAL STATUS
Patient vital status: ??

Enter 0 for alive or 1 for dead patients.

     Select one of the following:

          0         ALIVE
          1         DEAD

Patient vital status: 1  DEAD
Sequence: 1
          VITAL STATUS=DEAD
```

Walk / Wheelchair: If you want a report of patients by method of ambulation, use the Walk / Wheelchair filter.

```
Select Filter: WALK / WHEELCHAIR
Method of ambulation: ?

Enter 1 or 2 if the patient can walk, 3 or 4 if the patient uses
a wheelchair.

     Select one of the following:

          1         WALK WITHOUT HELP
          2         WALK WITH DEVICE
          3         MANUAL WHEELCHAIR
          4         MOTORIZED WHEELCHAIR

Method of ambulation: 4  MOTORIZED WHEELCHAIR
Beginning date: t-100  (SEP 18, 1999)
Ending date:   t  (DEC 27, 1999)
Sequence: 1
          AMBULATION=MOTORIZED WHEELCHAIR
Sequence: 1.1
          BEGINNING DATE=SEP 18,1999
          ENDING DATE=DEC 27,1999
```

SCD Reports Menu...

Filtered Reports...

In the following chapters on the individual filtered reports, assume that SCD filters are not being used with the reports. We will only display the sorts/filters that are specific to each report and that appear regardless of whether or not you choose to use the SCD filters.

SCD Ad Hoc Reports

```
[1]REG     Registration Ad Hoc Report
SEL      Self Report of Function Ad Hoc Report
FIM      FIM Ad Hoc Report
AS       ASIA Ad Hoc Report
CHA      CHART Ad Hoc Report
FAM      FAM Ad Hoc Report
DEN      DIENER Ad Hoc Report
DUS      DUSOI Ad Hoc Report
MS       Multiple Sclerosis Ad Hoc Report
OUT      Comprehensive Outcomes Ad Hoc Report

Select SCD Ad Hoc Reports Option:     REG     Registration Ad Hoc
Report
```

[1] Patch SPN*2.0*19 January 2003 – New options.

SCD Ad Hoc Report for Registry

Create reports in this option using data from the Registry.
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

```
================ Registration Ad Hoc Report Generator ================

 1 Patient               21 Describe Other          41 Annual Eval Received
 2 SSN                   22 Onset by Trauma         42 Next Annual Eval Due
 3 Date of Birth         23 MS Subtype              43 Last Annual Eval Offered
 4 Date of Death         24 Had Brain Injury?       44 Last Annual Eval Received
 5 Age                   25 Had Amputation?         45 Last Annual Eval Due
 6 Registration Date     26 Memory/Think Affected   46 Primary Care Provider
 7 Registration Status   27 Eyes Affected           47 SCD-Registry Coordinator
 8 Date of Last Update   28 One Arm Affected        48 Referral Source
 9 Last Updated By       29 One Leg Affected        49 Referral VA
10 Division              30 Both Arms Affected      50 Initial Rehab Site
11 SCI Network           31 Both Legs Affected      51 Init Rehab Discharge Date
12 SCI Level             32 Other Body Prt Affected 52 Bowel Care Reimbursement
13 VA SCI Status         33 Descr Other Body Part   53 BCR Date Certified
14 1Amount VA is Used    34 Extent of Movement      54 BCR Provider
15 Primary Care VAMC     35 Extent of Feeling       55 Sensory/Motor Loss
16 Annual Rehab VAMC     36 Bowel Affected          56 Class of Paralysis
17 Additional Care VAMC  37 Bladder Affected        57 Type of Injury
18 Non-VA Care           38 Remarks                 58 Enrollment Priority
19 Etiology              39 Extent of SCI
20 Date of Onset         40 Annual Eval Offered

Sort selection # 1 : ^
```

[1] Patch SPN*2.0*19 January 2003 – Revised field selection (fields 14, 47, & 58).

SCD Ad Hoc Report for CHART, FAM, DIENER, DUSOI

Create reports in this option using data from the Outcomes file of the Registry.
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

```
Select SCD Ad Hoc Reports Option:  [1]CHA     CHART Ad Hoc Report

    ================== CHART Ad Hoc Report Generator ==================

 1 Patient               9 Record Type            17 CHART Mobility
 2 SSN                  10 Score Type             18 CHART Occupation
 3 [2]Date of Birth      11 Division              19 CHART Social Interact
 4 Date of Death        12 Disposition            20 CHART Econ Self Suff
 5 Age                  13 Respondent Type        21 CHART Total Score
 6 Care Type            14 Date Recorded
 7 Care Start Date      15 CHART Physical Indep
 8 Care End Date        16 CHART Cognitive Indep

   Sort selection # 1 : ^
```

[1] Patch SPN*2.0*19 January 2003 – New options.
[2] Patch SPN*2.0*19 January 2003 – Revised field selection (fields 4-8).

SCD Ad Hoc Report for FIM

Create reports in this option using data from the Outcomes file of the Registry.
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

```
Select SCD Ad Hoc Reports Option: [1]FIM Ad Hoc Report

 ==================== FIM Ad Hoc Report Generator ====================

 1 Patient              15 Clinician              29 Stairs
 2 SSN                  16 Eating                 30 Comprehension Level
 3 Date of Birth        17 Grooming               31 Method of Comprehension
 4[2] Date of Death      18 Bathing                32 Expression Level
 5 Age                  19 Dressing Upper Body    33 Method of Expression
 6 Care Type            20 Dressing Lower Body    34 Social Interaction
 7 Care Start Date      21 Toileting              35 Problem Solving
 8 Care End Date        22 Bladder Management     36 Memory
 9 Record Type          23 Bowel Management       37 FIM Motor Score
10 Score Type           24 Xfer Bed/Chr/Whlchr    38 FIM Cognitive Score
11 Division             25 Xfer Toilet            39 FIM Total Score
12 Disposition          26 Xfer to Tub/Shower
13 Respondent Type      27 Walk/Wheelchair
14 Date Recorded        28 Method of Wlk/Whlchr

   Sort selection # 1 : ^
```

[1] Patch SPN*2.0*19 January 2003 – New options.
[2] Patch SPN*2.0*19 January 2003 – Revised field selection (fields 4-8).

SCD Ad Hoc Report for ASIA

Create reports in this option using data from the Outcomes file of the Registry.
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

```
     Select SCD Ad Hoc Reports Option: [1]AS  ASIA Ad Hoc Report


  ==================== ASIA Ad Hoc Report Generator ====================

 1 Patient              11 Division               21 Neurolevel-Motor L
 2 SSN                  12 Disposition            22 Complete/Incomplete
 3 Date of Birth        13 Respondent Type        23 Partial Pres-Sensory R
 4 [2]Date of Death      14 Date Recorded          24 Partial Pres-Sensory L
 5 Age                  15 Motor Score            25 Partial Pres-Motor R
 6 Care Type            16 Pin Prick Score        26 Partial Pres-Motor L
 7 Care Start Date      17 Light Touch Score      27 Highest Neuro Level
 8 Care End Date        18 Neurolevel-Sensory R   28 Impairment Scale
 9 Record Type          19 Neurolevel-Sensory L
10 Score Type           20 Neurolevel-Motor R

   Sort selection # 1 : ^
```

[1] Patch SPN*2.0*19 January 2003 – New option.
[2] Patch SPN*2.0*19 January 2003 – Revised field selection (fields 4-8).

SCD Ad Hoc Report for Multiple Sclerosis

Create reports in this option using data from the Outcomes file of the Registry.
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

```
   Select SCD Ad Hoc Reports Option: [1]MS  Multiple Sclerosis Ad Hoc Report


  ====================  MS Ad Hoc Report Generator  ====================

 1 Patient              10 Score Type             19 Cerebral
 2 SSN                  11 Division               20 Cerebellar
 3 Date of Birth        12 Disposition            21 Bowel & Bladder Funct
 4 [2]Date of Death      13 Respondent Type        22 Visual
 5 Age                  14 Date Recorded          23 Other
 6 Care Type            15 Clinician              24 EDSS
 7 Care Start Date      16 Pyramidal
 8 Care End Date        17 Brainstem
 9 Record Type          18 Sensory

   Sort selection # 1 : ^
```

[1] Patch SPN*2.0*19 January 2003 – New option.
[2] Patch SPN*2.0*19 January 2003 – Revised field selection (fields 4-8).

SCD Ad Hoc Report for Self-Report of Function

Create reports in this option using data from the Outcomes file of the Registry.
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

```
    Select SCD Ad Hoc Reports Option: [1]SEL Self Report of Function Ad Hoc Report


  ========== Self Report of Function Ad Hoc Report Generator =================

 1 Patient              14 Xfr Bed/Chr/Whlchr     27 Stairs
 2 SSN                  15 Xfer Tub/Shower        28 Get 2 Places Outside Home
 3 Date of Birth        16 Xfer to Toilet         29 Shopping
 4 [2]Care Type          17 Toileting             30 Planning Cooking Meals
 5 Care Start Date      18 Bladder Management     31 Doing Housework
 6 Care End Date        19 Bowel Management       32 Handling Money
 7 Record Type          20 Eating                 33 Help During Last 2 Weeks
 8 Score Type           21 Grooming               34 Number of Hours of Help
 9 Division             22 Bathing                35 Hrs of Hlp Last 24hrs
10 Disposition          23 Dressing Upper Body    36 Method Ambulation Walking
11 Respondent Type      24 Dressing Lower Body    37 Method Ambulation Whlchr
12 Date Recorded        25 Walk/Wheelchair
13 Mvment inside House  26 Method of Walk/Wheelchair

   Sort selection # 1: ^
```

[1] Patch SPN*2.0*19 January 2003 – New option.
[2] Patch SPN*2.0*19 January 2003 – Revised field selection (fields 4-6).

SCD Ad Hoc Report for Comprehensive Outcomes

Create reports in this option using data from the Outcomes file of the Registry.
See Appendix C – Using Ad Hoc Reports for more detail on Ad Hoc reporting.

Here are the fields available in this option for creating reports.

```
   Select SCD Ad Hoc Reports Option: [1]OUT  Comprehensive Outcomes Ad Hoc Report


  ================ SCD Outcomes Ad Hoc Report Generator ================

 1 Patient              33 Social Interaction     65 FAM Community Access
 2 SSN                  34 Problem Solving        66 FAM Reading
 3 Date of Birth        35 Memory                 67 FAM Writing
 4 Date of Death        36 Clinician              68 FAM Speech Intel
 5 Age                  37 To Places Otside Home  69 FAM Emotional Status
 6 [2]Care Type          38 Shopping               70 FAM Adj to Limitations
 7 Care Start Date      39 Planning Cooking Meals 71 FAM Employability
 8 Care End Date        40 Doing Housework        72 FAM Orientation
 9 Record Type          41 Handling Money         73 FAM Attention
10 Score Type           42 Method Amb Wlk         74 FAM Safety Judgement
11 Division             43 Method Amb Whlchr      75 Diener Composite Score
12 Disposition          44 Help During Last 2 Wks 76 DUSOI Composite Score
13 Respondent Type      45 Number of Hrs of Hlp   77 FIM Motor Score
14 Date Recorded        46 Hrs of Hlp Last 24Hrs  78 FIM Cognitive Score
15 Eating               47 Sensory Kurtzke        79 FIM Total Score
16 Grooming             48 Cerebral Kurtzke       80 ASIA Impairment Scale
17 Bathing              49 Cerebellar Kurtzke     81 Motor Score
18 Dressing Upper Body  50 Bwl Blad Funct Kurtzke 82 Pin Prick Score
19 Dressing Lower Body  51 Visual Kurtzke         83 Light Touch Score
20 Toileting            52 Other Kurtzke          84 Neurolevel-Sensory R
21 Bladder Management   53 Pyramidal Kurtzke      85 Neurolevel-Sensory L
22 Bowel Management     54 Brainstem Kurtzke      86 Neurolevel-Motor R
23 Xfer Bed/Chr/Whlchr  55 EDSS                   87 Neurolevel-Motor L
24 Xfer Toilet          56 CHART Physical Indep   88 Complete/Incomplete
25 Xfer Tub/Shower      57 CHART Mobility         89 Partial Pres-Sensory R
26 Walk/Wheelchair      58 CHART Occupation       90 Partial Pres-Sensory L
27 Method of Wlk/Whlchr 59 CHART Social Interact  91 Partial Pres-Motor R
28 Stairs               60 CHART Econ Self Suff   92 Partial Pres-Motor L
29 Comprehension Level  61 CHART Cognitive Indep  93 Highest Neuro Level
30 Method of Comp       62 CHART Total Score
31 Expression           63 FAM Swallowing
32 Method of Expression 64 FAM Car Transfers

   Sort selection # 1 : ^
```

[1] Patch SPN*2.0*19 January 2003 – New option.
[2] Patch SPN*2.0*19 January 2003 – Revised field selection (fields 6-8).

SCD Reports Menu...
Filtered Reports...

Basic Patient Information (132 Column)

This report prints the patient's Name, SSN, DOB, Phone, Street Address 1, Street Address 2, City, State, and Zip Code on a single line. It is designed for 132-column printing/displaying. Therefore, if printing a hardcopy, send it to a 132-column printer or subtype. If displaying to screen for file capture, at the DEVICE prompt enter 0;132;9999 without spaces.

```
### This report is designed for 132 column viewing/printing     ###
### Set your terminal display to 132 columns                    ###
### For screen viewing, answer DEVICE prompt with 0;132         ###
### For file capture, answer DEVICE prompt with 0;132;9999      ###
### For a hardcopy, answer with a 132 column printer or subtype ###

Select DEVICE: HOME// 0;132;9999  VIRTUAL/CURRENT DEVICE
```

```
                                ********** BASIC PATIENT INFORMATION **********
                                                12/29/1999

Patient            SSN          DOB         Phone          Street Address 1        Street Address 2   City           St Zip

ARMSTRONG,BT       445-67-8989  09/11/1960  708-786-5555   123 STADIUM  AVE                           CHICAG         IL 60612

PEOPLES,BARNEY     332-45-6754  01/11/1945  708-786-3333   543 LANDIS AVE                             CHICAG         IL 60000
```

SCD Reports Menu...
Filtered Reports...

Breakdown of Patients

This report breaks down the caseload of patients. You can specify only living patients or all patients (including those who are deceased) and you can limit your report to a specific period.

```
Include deceased patients?  NO// YES

Include only those patients seen during a specified period?  NO// Y  YES

Start date for period:  1/1/99  (JAN 01, 1999)
  End date for period:  (1/1/1999 - 12/29/1999): TODAY// <RET>  (DEC 29,
1999)
DEVICE: HOME// (Enter a device)


Gathering patient data…
```

SCD - Patient Registry Breakdown
SUPPORT ISC
Active Patients Currently Alive Seen During the Period 01/01/99 to 12/29/99

	Female	Male	Total
Total	2	8	10
20-24 years		1	1
35-39 years		1	1
45-49 years	1		1
50-54 years	1	2	3
55-59 years		1	1
65-69 years		1	1
85-89 years		2	2
ASIAN		1	1
BLACK		1	1
CAUCASIAN		1	1
HISPANIC, WHITE	1	1	2
UNSPECIFIED RACE		2	2
WHITE, NOT OF HISPANIC ORIGIN	1	2	3
Means Test CATEGORY A		1	1
Means Test NO LONGER REQUIRED	1	2	3
Means Test NOT REQUIRED		4	4
Means Test REQUIRED	1	1	2
NSC	1	3	4
SC LESS THAN 50%	1		1
SERVICE CONNECTED 50% to 100%		2	2
UNSPECIFIED ELIGIBILITY		3	3
OTHER OR NONE		1	1
POST-VIETNAM		1	1
PRE-KOREAN		1	1
UNSPECIFIED PERIOD OF SERVICE		3	3
VIETNAM ERA	2		2
WORLD WAR II		2	2
Seen in Laboratory	1		1
Seen as Inpatient	2	5	7
Seen as Outpatient	1	3	4
Seen in Radiology	2	8	10

SCD Reports Menu...
Filtered Reports...

[1]CHART/FAM/DIENER/DUSOI Scores

This report provides CHART/FAM/DIENER/DUSOI scores for a patient or group of patients. The acronyms are described as follows:

CHART - Craig Handicap Assessment and Reporting Technique
FAM - Functional Assessment Measure
DIENER - Diener's Satisfaction with Life Scale
DUSOI - Duke University Severity of Illness Index

CHART

```
            1     CHART
            2     FAM
            3     DIENER
            4     DUSOI


Pick an Outcome report from above list: 1
Select a patient: CATT,PATIENT         08-08-63     666770000     YES
MILITARY RETIREE
Select a patient: <RET>
One Moment Please...
DEVICE: [Enter a device name]
```

```
Patient:  CATT,PATIENT                    SSN: 666770000  DOB: AUG  8,1963
------------------------------------------------------------------------------
                                   CHART Scores

                              Date Recorded   SEP 24,1999

         Craig Handicap Assessment and Reporting Technique(CHART)


            Physical Independence:     50
                        Mobility:     65
                    Occupation:     42
               Social Interaction:     87
        Economic Self Sufficiency:     33
          Cognitive Independence:     90
                                  ----------
                Chart Total Score:    367
```

[1] Patch SPN*2.0*19 January 2003 – New Option and dysplay.

[1]FAM

```
            1     CHART
            2     FAM
            3     DIENER
            4     DUSOI


Pick an Outcome report from above list: 2
Select a patient: CATT,PATIENT         08-08-63     666770000     YES
MILITARY RETIREE
Select a patient: <RET>
One Moment Please...
DEVICE: [Enter a device name]
```

```
Patient: DAVIDSON,HARLEY               SSN: 496016821    DOB: 05/25/1919
------------------------------------------------------------------------------
                Functional Assessment Measure (FAM)

                      Date Recorded: 01/20/2000


                                    Swallowing: SUPERVISION
                   Car Transfers: MAXIMAL ASSISTANCE
                Community Access: TOTAL ASSISTANCE
                         Reading: COMPLETE INDEPENDENCE
                         Writing: COMPLETE INDEPENDENCE
           Speech Intelligibility: COMPLETE INDEPENDENCE
                 Emotional Status: SUPERVISION
        Adjustment to Limitations: MINIMAL ASSISTANCE
                    Employability: TOTAL ASSISTANCE
                      Orientation: MODIFIED INDEPENDENCE
                        Attention: SUPERVISION
                Safety Judgement: SUPERVISION
```

[1] Patch SPN*2.0*19 January 2003 – New Option and dysplay.

[1]DIENER

```
            1     CHART
            2     FAM
            3     DIENER
            4     DUSOI

Pick an Outcome report from above list: 3
Select a patient: CATT,PATIENT         08-08-63     666770000     YES
MILITARY RETIREE
Select a patient: <RET>
One Moment Please...
DEVICE: [Enter a device name]
```

```
Patient: DAVIDSON,HARLEY               SSN: 496016821    DOB: 05/25/1919
------------------------------------------------------------------------------
                Diener's (1985) Satisfaction with Life Scale

                        Date Recorded: 07/28/2001


                        Diener Composite Score: 34
```

DUSOI

```
            1     CHART
            2     FAM
            3     DIENER
            4     DUSOI


Pick an Outcome report from above list: 4
Select a patient: CATT,PATIENT         08-08-63     666770000     YES
MILITARY RETIREE
Select a patient: <RET>
One Moment Please...
DEVICE: [Enter a device name]
```

```
Patient: DAVIDSON,HARLEY               SSN: 496016821    DOB: 05/25/1919
------------------------------------------------------------------------------
                Duke University of Illness Index (DUSOI)

                        Date Recorded: 07/28/2001


                        DUSOI Composite Score: 34
```

[1] Patch SPN*2.0*19 January 2003 – New Option and dysplay.

SCD Reports Menu...
Filtered Reports...

Current Inpatients

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

The Current Inpatients report shows those patients in your local SCD registry who are currently on an inpatient status.

```
                          SCD - Current Inpatients
                                SUPPORT ISC
                             Total Inpatients:  4

                                 Last                          Admission  Curr   FYTD
Name                             Four   Ward                      Date     LOS    LOS

TEST,D                           4444   2AS                     06/15/99   198    180
     Adm dx: QUADRAPLEGIA               Room-Bed: 310-1
CAMPBELL,SOUP                    4444   3AS                     04/04/96 1,365     90
     Adm dx: TRAUMATIC PARAPLEGIA       Room-Bed: 310-2
CANUSEE,JOSE                     6666   6AS                     04/02/96 1,367     90
     Adm dx: PROSTATIC CA               Room-Bed: 312-1
BIRD,K G                         9870   7AS                     04/03/98   636     90
     Adm dx: QUADRAPLEGIA               Room-Bed: 312-2
```

SCD Reports Menu...
Filtered Reports...

Expanded Patient List (255 Column)

This report is designed for spreadsheet use. It displays the Patient, SSN, Home Phone, NtWk, Reg Status, Address including County, Last AE Offered, Last AE Received, Primary VA, Provider, SCI, Level Etiology, and Date Occ.

```
### This report is designed for importing into a spreadsheet    ###
### Turn OFF line wrap.  Capture file as raw text               ###
### For file capture, answer DEVICE prompt with 0;255;9999      ###
### File will import into spreadsheet, 1 patient per row        ###

Select DEVICE: HOME// 0;255;9999 (Set the file capture before pressing the
<RET> key.) <RET>TELNET
```

SCD Reports Menu...
Filtered Reports...

Patients with Future Appointments

This report lists patients having future clinic appointments within a user specified date range. A prompt allows you to select patients in the SCD Registry or patients not in the SCD Registry but with a Spinal Cord Injury (as determined from the patient file), or you can select both. This report can be of great assistance in keeping your Registry up to date.

```
Enter a START date: OCT 3,2000// <ret> (OCT 03, 2000)
Enter a ENDING date: OCT 17,2000//1003  (OCT 04, 2000)

     Select one of the following:

          1         Patients in the Registry only.
          2         Patients marked as SCI but not in the Registry.
          3         Both.

Enter response: 1  Patients in the Registry only.
Select DEVICE: HOME//   (Enter a Device)
```

```
                        Patients in the Registry only
                          Listing appointments from          Page: 1
                        OCT 3,2000 TO OCT 4,2000@23:59

Appointment date
Time  Clinic      Patient     SSN   Reg   SCI   SCI
                        Status      LVL   NETWRK
OCT 3,2000
-------------------------------------------------------------------------------
07:00 AMB[DAY]SURG/AREA 5N    ONEIL,XXXXXXX     NNNN  SCD-CURRENT L04   YES
08:30 4N-RM 4016-PULM-SLEE    RAVAGO,XXXXXX     NNNN  SCD-CURRENT       YES
08:30 DERM F/U LJ-CHEN-A      ARTHERTON,XXX     NNNN  SCD-CURRENT
08;40 UROLOGY-NURSE-AREA 1    BENNETT,XXXXX     NNNN  SCD-CURRENT L03

OCT 4,2000
-------------------------------------------------------------------------------
08:00 AMB[ORTHO]SURG/NP/PR    ABRAM,XXXXXXX     NNNN  SCD-CURRENT C07   YES
08:02 DENTAL CLINIC     SOAPES,XXXXXX     NNNN  SCD-CURRENT T12   YES
08:10 AMB[PHYSICAL THERAPY    ABRAM,XXXXXXX     NNNN  SCD-CURRENT       C07
      YES
```

SCD Reports Menu...
Filtered Reports...

Functional Independence Measures

[1]This report is designed to print out FIM (Functional Independence Measure) scores for a patient or a group of patients.

```
Select a patient: CAMPBELL,SOL           01-02-50     359814444     NO
PILL

 Enrollment Priority:           Category: IN PROCESS    End Date:


Select a patient: <RET>

One Moment Please...
DEVICE: (Enter a device)
```

[1] Patch SPN*2.0*19 January 2003 – Revised option description.

```
   CAMPBELL,SOL                SSN: 359814444  DOB:   JAN  2,1950
------------------------------------------------------------------------------
                        Functional Independence Measures (FIM)
                             Date Recorded:  DEC 17,1999
                              Score Type: INPT START
Disposition: 3 HOME ASSISTED
                                   Clinician(s)
                                   ADAMS,JACKIE
------------------------------------------------------------------------------
                                     Self Care
                               Eating:  MINIMAL ASSISTANCE
                             Grooming:  MINIMAL ASSISTANCE
                              Bathing:  MAXIMAL ASSISTANCE
                  Dressing Upper Body:  MODERATE ASSISTANCE
                  Dressing Lower Body:  MODERATE ASSISTANCE
                            Toileting:  MAXIMAL ASSISTANCE
                                   Sphincter Control
                   Bladder Management:  TOTAL ASSISTANCE
                     Bowel Management:  TOTAL ASSISTANCE

                             Mobility/Transfer
      Transfer Bed/Chair/Wheel chair:  MAXIMAL ASSISTANCE
                  Transfer to toilet:  MODERATE ASSISTANCE
              Transfer to Tube/Shower:  MODERATE ASSISTANCE

                                    Locomotion
            Method of Walk/Wheelchair:  WHEELCHAIR
                      Walk/Wheelchair:  MODIFIED INDEPENDENCE
                               Stairs:  TOTAL ASSISTANCE
                                        ----------
                           Motor Score:  35.0

                                   Communication
                 Comprehension Method:  BOTH
                  Comprehension Level:  COMPLETE INDEPENDENCE
                    Expression Method:  BOTH
                     Expression Level:  COMPLETE INDEPENDENCE
                                   Social Cognition
                   Social Interaction:  COMPLETE INDEPENDENCE
                      Problem Solving:  COMPLETE INDEPENDENCE
                               Memory:  COMPLETE INDEPENDENCE
                                        ----------
                      Cognitive Score:  35.0

                                        ----------
                      Total FIM Score:  70.0
```

SCD Reports Menu...
Filtered Reports...

Follow-Up (Last Annual Rehab Eval Received)

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

This report identifies patients who have not had a rehab evaluation within a specified period of time. You are prompted to select that period of time. The system default is 180 days prior to TODAY and is displayed as (180D//). An authorized user (i.e., one who possesses the SPNL SCD MGT key) can change it through the Edit Site Parameters option. "Last Four" in the report header refer to the last four digits of the patient's SSN.

```
Show patients whose last physical exam was more than how long ago?: 180D//
<RET> 180D

DEVICE: [Enter a device name]

Gathering patient data
```

```
                          SCD - Patient Follow Up
                                SAN DIEGO, CA
                   Patients at Risk of Loss to Follow Up
     (Last Annual Rehab Eval Received over 180 Days ago, before 12/10/97)

Last Eval     Name                                Last Four

01/02/1997     SMITH,GERALD                          2043
01/08/1997      CAMPBELL,JOHN                         4444
```

SCD Reports Menu...
Filtered Reports...

Follow-Up (Last Seen)

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

This report identifies patients who have not been seen at your facility within a specified period of time. You are prompted to select a period of time. The system default is 180 days prior to TODAY and is displayed as (180D//). It can be changed through the Edit Site Parameters option by an authorized user (i.e., possessing the SPNL SCD MGT key).

The report displays the patients and the last four digits of their SSNs.

```
Show patients last seen more than how long ago?: 180D// <RET> 180D

DEVICE: (Enter a device)

Gathering patient data
```

```
                          SCD - Patient Follow Up
                                SAN DIEGO, CA
                    Patients at Risk of Loss to Follow Up
              (Not seen in over 180 Days, since before 07/02/99)

Last Seen     Name                                 Last Four

04/16/1999     MATISSE,HENRI                           9123
04/20/1999      BUREN VAN,MARTIN                        0123
```

SCD Reports Menu...
Filtered Reports...

Health Summary

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

The Health Summary option integrates clinical data from ancillary support modules into patient health summaries, which can be viewed by clinicians on monitors or as printed reports.

The Health Summary option integrates clinical data from the following VISTA modules:

PIMS Medicine
PIMS Scheduling Laboratory
Outpatient Pharmacy Vital Signs
IV Pharmacy Dietetics
Unit Dose Pharmacy Surgery
Radiology/Nuclear Medicine CPRS
Text Integration Utility

Clinicians are able to select from a list of predefined Health Summary types. Examples of clinical patient data that can be retrieved are listed below:

Demographics Admissions
Discharges Past and Future Clinic Visits
Radiology Procedures Surgical Procedures
Medical Procedures Transfers
Medications Lab Results
Temperature/Pulse/Blood Pressure

For more information on Health Summary, refer to the VISTA Health Summary User's manual.

```
Select PATIENT:  CAMPBELL,SOL         03-05-23     435243515     YES     SC
VETERAN
Select Health Summary Type Name:  SAMPLE ONLY
DEVICE: [Enter a device name])
```

```
11/18/96 10:24
*********************  CONFIDENTIAL SAMPLE ONLY SUMMARY
*********************
CAMPBELL,SOL    435-24-3515                                    DOB: 03/05/23

------------------------- MEDS - Med (1 line) Summary ----------------------


MAR 14,1996@13:52      BRONCHOSCOPY
------------------------------------------------------------------------------
            Summary:   NORMAL
  Procedure Summary:   This is a summary of the procedure ...

FEB 28,1996@13:08      PULMONARY FUNCTION TEST
------------------------------------------------------------------------------
....



* END *
```

SCD Reports Menu...
Filtered Reports...

Inpatient/Outpatient Activity

This option produces reports on inpatients and outpatients over a specific range of dates.

Note: A "stop" is credited for each entry of a stop code. A "visit" is distributed among each stop credited on a given date. Thus, a single visit with two stop codes credited shows as 0.5 visit for each stop code. A total of 1.00 visit is given for outpatient activity on a given date.

The "Number of highest users to identify" refers to the number of patients to show on the report that were the most active.

```
Start date for period:  1/1/99  (JAN 01, 1999)
  End date for period:  (1/1/1999 - 12/29/1999): TODAY// <RET>  (DEC 29,
1999)


Number of highest users to identify:  (0-100): 0// 2
DEVICE: HOME// [Enter a device name]

Gathering patient data
```

```
                  SCD - Inpatient and Outpatient Activity
                                SUPPORT ISC
                             Outpatient Activity
                       For the Period 01/01/99 to 12/29/99

                Totals:  8 patients for 116 visits (204 stops)

    Patients    Visits

           1        81
           1        12
           1        10
           2         4
           2         2
           1         1
```

SCD - Inpatient and Outpatient Activity
SUPPORT ISC
Outpatient Activity
For the Period 01/01/99 to 12/29/99

Clinic	Patients	Visits	Stops
102. ADMITTING/SCREENING	1	2.00	2
105. X-RAY	1	1.00	1
108. LABORATORY	1	2.50	7
203. AUDIOLOGY	8	99.33	179
204. SPEECH PATHOLOGY	2	2.83	4
216. TELEPHONE/REHAB AND SUPPORT	1	3.33	6
301. GENERAL INTERNAL MEDICINE	1	4.00	4
557. PSYCHIATRY-GROUP	1	1.00	1

SCD - Inpatient and Outpatient Activity
SUPPORT ISC
Outpatient Activity
For the Period 01/01/99 to 12/29/99

Highest Utilization of Visits

Patient Name	SSN	Visits	Different Stop Codes
SMITH,PATIENT	111-11-2043	81	3
LIME,PATIE	389-38-9467	12	3

SCD - Inpatient and Outpatient Activity
SUPPORT ISC
Inpatient Activity
For the Period 01/01/99 to 12/29/99

Totals: 7 patients for 11 stays and 1,722 days inpatient care

Patients	Stays
4	1
2	2
1	3

SCD - Inpatient and Outpatient Activity
SUPPORT ISC
Inpatient Activity
For the Period 01/01/99 to 12/29/99

Median Length of Stay (MLOS): 198.0 days

Specialty	Patients	Stays	Days	MLOS
DOMICILIARY	1	1	13	13.0
GENERAL SURGERY	3	3	922	363.0
GENERAL(ACUTE MEDICINE)	1	1	221	221.0
MEDICAL OBSERVATION	4	6	204	1.0
NHCU	1	1	363	363.0

SCD - Inpatient and Outpatient Activity
SUPPORT ISC
Inpatient Activity
For the Period 01/01/99 to 12/29/99

Highest Number of Stays

Patient Name	SSN	Stays	Days
LIME,PATIE	389-38-9467	3	211
ARMSTRONG,PA	445-67-8989	2	222
HARPER,PATIE	578-65-7687	2	2

SCD - Inpatient and Outpatient Activity
SUPPORT ISC
Inpatient Activity
For the Period 01/01/99 to 12/29/99

Highest Number of Days

Patient Name	SSN	Days	Stays
CANUSEE,PATI	444-22-6666	363	1
BIRD,PAT	342-56-9870	363	1
CAMPBELL,PATI	359-81-4444	363	1
ARMSTRONG,PA	445-67-8989	222	2

SCD Reports Menu ...
Filtered Reports ...

Inpatient/Outpatient Activity (Specific)

This option is used to obtain information on patients in your local SCD registry who have utilized specific inpatient or outpatient resources. For outpatient activity, the option indicates the number of visits during the indicated time period to the clinic STOP CODE(s) specified. The number of stays and length of stay within a specific Specialty indicate inpatient activity.

On selection of this option, you are asked to define the starting and ending dates for the analysis, and the desired clinic Stop Code. The stop code is the subject area indicator for outpatient activity reported to Austin. You may select any number of stops codes by name or number.

Following a null response, you are asked to specify a specialty name for specific inpatient activity. The specialty names which may be selected are restricted to those used for reporting on the Patient Treatment File (PTF).

A "stop" is credited for each entry of a stop code, while a "visit" is distributed among each stop credited on a given date. Thus, a single visit with two stop codes credited shows as 0.5 visit for each stop code. A total of 1.00 visit is given for outpatient activity on a given date.

```
Start date for period:  JAN 1 95  (JAN 01, 1995)
  End date for period:  (1/1/95 - 11/18/96): TODAY// <RET> (NOV 18, 1996)

Select a CLINIC STOP: <RET>
Select a SPECIALTY: 15  GENERAL(ACUTE MEDICINE)
 Another SPECIALTY: <RET>
Do you want to see patient usage data?  YES// <RET>
DEVICE: [Enter a device name]

Gathering patient data
```

```
              SCD - Specific Inpatient and Outpatient Activity
                          Your Facility Name Here
                       Selected Inpatient Activity
                    For the Period 01/01/95 to 11/18/96

                          GENERAL(ACUTE MEDICINE)
Totals:  1 patient                                  2           19

Patient Name                      SSN              Stays         Days

SMITH,PATIENT                  555-12-3456           2           19
```

SCD Reports Menu ...
Filtered Reports ...

New SCI/SCD Patients

This option produces a report on new SCI/SCD patients in the SCD registry. You will be prompted to select a range of dates for this report.

```
Report Filter:
   Enter Original Registration START Date: 7/99  (JUL 1999)
   Enter Original Registration END Date: T  (MAY 11, 2000)
Select DEVICE: [Enter a device name]
```

```
May 11, 2000@09:34:02                                              Page: 1
                  Listing of NEW SCD/SCI Patients Since Jul 1999
Patient             SSN          Original    Etiology            VA SCI Status
                                 Regis Date
--------------------------------------------------------------------------------
AAHOLYIHU,ELUUN C   545-97-0781  09/20/1999  TUMOR               PARAPLEGIA-NONT
AKULZ,PDAADH        244-56-9790  08/20/1999  ARTHRITIC DISEASE   QUADRIPLEGIA-NO
BHAMUXKHUST,KXK T   580-05-9612  01/07/2000  OTHER - TRAUMATIC   PARAPLEGIA-TRAU
BHQHUAN,IXRFALT P   346-28-4723  10/12/1999  VEHICULAR           PARAPLEGIA-TRAU
BLFLATX,CXTH D      509-54-7473  09/29/1999  ARTHRITIC DISEASE   QUADRIPLEGIA-NO
BROSXY,HUYHTS K     468-83-0224  09/20/1999  VEHICULAR           QUADRIPLEGIA-TR
BRUBH,ZXTHT C       547-06-9065  11/30/1999  FALL                QUADRIPLEGIA-TR
BULYYXY,CXEY T      460-46-0810  01/06/2000  MULTIPLE SCLEROSIS  QUADRIPLEGIA-NO
BXAIHY,LUYXAI YZY   268-26-3139  11/10/1999  ACT OF VIOLENCE     PARAPLEGIA-TRAU
BXSSAH,KHHU         011-11-9999  07/07/1999  VEHICULAR           QUADRIPLEGIA-TR
CLTAHU,UXKHUS H     327-76-0575  08/30/1999  MULTIPLE SCLEROSIS  QUADRIPLEGIA-NO
CLUKRAADIX,WHSHU J  585-36-9606  09/07/1999  OTHER - DISEASE     PARAPLEGIA-NONT
CLZWKHAA,PLASHU J   382-63-0096  12/01/1999  MULTIPLE SCLEROSIS  PARAPLEGIA-NONT
CMHUYDHPTBD,TSLYAH  464-09-5878  08/19/1999  VEHICULAR           PARAPLEGIA-TRAU
```

SCD Reports Menu...
Filtered Reports...

Mailing Labels

This option produces mailing labels for patients in the SCD registry.

The following is a step-by-step procedure for using this option, your PC's terminal emulator, and Microsoft Word to print properly formatted mailing labels.

How to Create Mailing Labels from SCD Registry

1. From your SCD Reports menu, select FIL (Filtered Reports). Answer a Yes/No prompt regarding filters (a Yes answer enables you to custom select the patients). You then select the ML (Mailing Labels) filtered reports option. If you chose to use filters, answer the filtered prompts as desired.

2. At the prompt "Select DEVICE:", hit return. You will see the message "Prepare to capture list: Hit return when you are ready:"

   ProComm users: Click the file capture icon on your toolbar (looks like a butterfly net). Hit return. This starts the file capture. Wait momentarily. When you see "---END---", click the file capture icon again to close the capture. Hit return again. You now have captured the file onto your PC. Minimize or close ProComm. (Note: If your captured file contains fewer than 24 records, you may need to edit the file and remove the unnecessary lines at the top.)

   Smart Term users: Click Tools, then click Start Capture. A dialogue box will appear where you can specify the file name and the directory for saving the file. It is recommended you save it in the same directory as your Microsoft Word documents. Then click the Start Capture button in the dialogue box. Hit return. This starts the file capture. Wait momentarily. When you see "---END---", click Tools, and click Stop Capture to close the capture. Hit return again. You now have captured the file onto your PC. Minimize or close SmartTerm.

Example:

```
Select DEVICE: <RET>

Prepare to capture list: Hit return when you are ready:
When you see ---END--- Close the capture file and hit return.
<RET>
```

```
FNAME,LNAME,ADDRESS1,ADDRESS2,ADDRESS3,CITY,STATE,ZIPCODE
CRADLY,TXUZDT,5160 E HAWTHORNE DRIVE,,,ACRETON,SC,22303
QDYJHYS,HLNHT,12404 NACIDO DR,,,ST BERNARD,NE,01433
LAGUHI,DXQH,655 JEFFERSON AVE,,,BEAVERSTON,MT,53840
JALRIHSSH,PLYMHJL,3842 CAMEO LANE ,,,LOS DIABLOS,DE,76565
FUHFXUN,MXSSDYX,400 N THE STRAND  43,,,CLOVER,NJ,32456
IXYLAI,HDAA,5233 LA JOLLA HERMOSA AVE,,,NOD HILL,AR,43102
HIDSE,RRTE,7216 SAN RAMON,,,MAYBERRY,UT,26724
IXUXSEN,KHAAN,15720 BERNARDO CENTER DR,,,ACRETON,GA,71612
HAZHU,LLGUHYDHUH,3285 ASHFORD ST.,,,SPEEDTRAP,OK,77287
CLZHT,CXQDAAH,3350 LA JOLLA VILLAGE DRIVE,,,PADDLETON,MO,48406

---END---
```

3. Start Microsoft Word.

   a) Click File then "Open" and open the capture file. Save the capture file as a Word document.

   b) Click File again, then "New".

   c) Click Tools, then click Mail Merge. At the Mail Merge Helper, click #1 Create, click Mailing Labels, then click "Active Window". Next, click #2 "Get Data". Choose "Open Data Source" then find and select the capture file. Click "Set up Main Document" button (a Label Options box will appear). Select the type of label you will be using (ex: Avery Labels 5160), then click OK…A Create Labels box appears next. Click "Insert Merge Field" (IMF) button. Begin arranging your mailing labels by clicking "**FNAME**" then hit "Enter", hit space bar to insert a space then click IMF button to insert **"LNAME",** click the IMF button again, click "**ADDRESS 1**" then hit "Enter". Click the IMF button again then click "**ADDRESS 2**" then hit "Enter". Click IMF button again, then click "**ADDRESS 3**" then hit "Enter". Click the IMF button again to insert **"CITY",** then enter a comma and a space. Click IMF button again, then click **"STATE".** Press space bar twice, click IMF button, then click **"ZIP CODE".** Then click OK.

   Note: Your mailing label arrangement should look like this…

   <<FNAME>> <<LNAME>>
   <<ADDRESS 1>>
   <<ADDRESS 2>>
   <<ADDRESS 3>>
   <<CITY>>, <<STATE>> <<ZIP CODE>>

   Click #3, Merge. A "Merge" dialog box appears. Click Merge.

SCD Reports Menu...
Filtered Reports...

Patient Listing

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

This option produces a report of patients from your local SCD registry. The report includes Patient Name, SSN, Date of Birth and, if there is a Date of Death in the Patient File, the notation "Deceased."

This report is designed for 132 column viewing/printing
Set your terminal display to 132 columns
For screen viewing, answer DEVICE prompt with 0;132
For file capture, answer DEVICE prompt with 0;132;9999
For a hardcopy, answer with a 132 column printer or subtype

```
Select DEVICE: (Enter a device)
```

```
Patient Listing                                          Date: 05/11/2000
-------------------------------------------------------------------------------
Patient       SSN          DOB          Eligibility      Means     LOI  Prov. Et
-------------------------------------------------------------------------------
AAAHY,CXEY X  544-16-5786  JUL 15,1933  NSC              VERIFIED            O
AAAHY,JELUAH  044-95-2794  NOV 19,1950  SC LESS THAN 50  VERIFIED            M
AAAHY,JELUAH  264-49-0235  SEP 12,1950  AID & ATTENDANC  VERIFIED  T04  KELLY A9
AADXSX,CXTHW  564-86-2376  MAY 2,1937   NSC              VERIFIED            M8
AAHOLYIHU,EL  545-97-0781  FEB 20,1943  NSC              VERIFIED  T02  KELLY T0
AAJLULT,CXEY  546-36-5184  JAN 25,1949  SERVICE CONNECT  VERIFIED  T10       O6
AAKHUSTHY,SH  466-28-4477  JUL 29,1950  SC LESS THAN 50                     O
AALFYL,LYSEX  382-95-1546  APR 29,1937  NSC              VERIFIED  T12       F8
AASLZDULYX,U  531-72-7183  AUG 16,1956  AID & ATTENDANC  VERIFIED  C05       V8
AAXYMX,UXKHU  288-35-3543  NOV 3,1955   SERVICE CONNECT  VERIFIED  C05       O8
AFLWLN,CXTH   291-92-9108  NOV 19,1956  SERVICE CONNECT  VERIFIED  T04       O5
```

SCD Reports Menu...
Filtered Reports...

Patient Listing (Sort by State and County)

You must be authorized to invoke this option (i.e., you must possess the SPNL SCD PTS security key) to preserve patient confidentiality.

This option produces a report of patient data from your local SCD registry, which is sorted by state and county.

```
### This report is designed for 132 column viewing/printing     ###
### Set your terminal display to 132 columns                    ###
### For screen viewing, answer DEVICE prompt with 0;132         ###
### For file capture, answer DEVICE prompt with 0;132;9999      ###
### For a hardcopy, answer with a 132 column printer or subtype ###

Select DEVICE: HOME// 0;132  VIRTUAL/CURRENT DEVICE

Patient Listing by State and County
```

```
-------------------------------------------------------------------------------------------------------------------------------
Patient       SSN          DOB          Eligibility      Means     LOI  Prov. Etiology           Date Occ    AE Receivd  AE Next
-------------------------------------------------------------------------------------------------------------------------------
State: ALABAMA          County: BARBOUR
CLZWKHAA,PLA  382-63-0096  AUG 1,1933   NSC              VERIFIED  T09  OCONN MULTIPLE SCLEROSIS 00/00/1986

State: ALABAMA          County: BLOUNT
TERUZLY,LAKH  540-03-1450  JUN 27,1966  SERVICE CONNECT  VERIFIED  T10  GERHA VEHICULAR         11/04/1996  03/23/1998
03/23/1999

State: ALABAMA          County: BUTLER
CELYIAHU,WED  503-95-0154  JUL 21,1926  NSC              VERIFIED            OTHER

State: ALABAMA          County: BUTLER
MXXUH,CLZHT   383-14-1479  NOV 5,1944   NSC                                  OTHER

State: ALABAMA          County: BUTLER
VXHASMHA,UDJ  586-64-5475  JAN 15,1947  SERVICE CONNECT  VERIFIED  T12       VEHICULAR         04/00/1967

State: ALABAMA          County: CHILTON
RLZDUHM,ULRA  307-81-0313  FEB 20,1966  SERVICE CONNECT  VERIFIED  C05       VEHICULAR         03/18/1995  05/13/1998
05/13/1999
```

SCD Reports Menu...
Filtered Reports...

Registrant General Report

The Registrant General Report option produces a standard VA FileMan report that allows for individual customization. Patient data associated with active and inactive SCD Registrants are extracted exclusively from your local SCD registry. Enter two question marks (??) at any prompt to receive help.

```
SORT BY: NUMBER// <RET>
START WITH NUMBER: FIRST// <RET>
DEVICE: [Enter a device name]
```

```
SCD Registrant General Report                  MAY 11,2000  11:04    PAGE 1
PATIENT                    SSN           DOB           REGISTR DATE  STATUS
  LAST ANN     SERVICE    LAST
  EVAL RECD    CONNECTED  UPDATED
--------------------------------------------------------------------------------
         NUMBER: 74
TXUZDT,CRADLY U          565578402     03/25/1952    MAY 22,1995   SCD - CURRENT
  OCT 22,1997  YES          APR  4,2000
        NUMBER: 77
SZDSE,IXYLAI J           141603974     05/14/1923    JUN 30,1995   EXPIRED
  NOV 27,1989  YES          SEP  1,1999
        NUMBER: 173
GDAKHUS,JULDF W          402715724     07/31/1925    JUN 30,1995   EXPIRED
  APR  2,1990               NOV 12,1999
        NUMBER: 238
HLNHT,QDYJHYS I.         521924616     04/25/1924    JUN 30,1995   SCD - CURRENT
  OCT 28,1993  NO           OCT  2,1998
        NUMBER: 259
DXQH,LAGUHI J            503841648     06/06/1924    MAY 17,1995   SCD - CURRENT
  JAN  7,1998  NO           MAR 26,1999
....
```

SCD Reports Menu...
Filtered Reports...

Registrant Injury Report

This option produces a standard VA FileMan report that allows for individual customization. Patient data associated with active and inactive SCD registrants are extracted exclusively from your local SCD registry. Enter two question marks (??) at any prompt to receive help.

```
SORT BY: NUMBER// <RET>
START WITH NUMBER: FIRST// <RET>
DEVICE: [Enter a device name]
```

```
SCD Registrant Injury Report                    MAY 11,2000  11:11    PAGE 1
                                                  SCI    EXTENT OF
PATIENT                   SSN        DOB        LEVEL       SCI
                                                DATE OF
  INFO SOURCE FOR SCD   ETIOLOGY              ONSET        TRAUMA
-------------------------------------------------------------------------------
---------
         NUMBER: 74
TXUZDT,CRADLY U       565578402  03/25/1952   C04    INCOMPLETE
  CHART REVIEW          FALL                DEC 1980     TRAUMATI
        NUMBER: 77
SZDSE,IXYLAI J        141603974  05/14/1923
  PATIENT HISTORY
        NUMBER: 173
GDAKHUS,JULDF W       402715724  07/31/1925
  PATIENT HISTORY
        NUMBER: 238
HLNHT,QDYJHYS I.      521924616  04/25/1924
  PATIENT HISTORY       MULTIPLE SCLEROSIS   1967        NON-TRAU
        NUMBER: 259
DXQH,LAGUHI J         503841648  06/06/1924   L02
  CHART REVIEW          ACT OF VIOLENCE     DEC 1943     TRAUMATI
...
```

SCD Reports Menu...
Filtered Reports...

[1]Self Report of Function

Use this option to obtain the Self-Report of Function scores for a patient or a group of patients. Enter ALL at the "Select a patient" prompt to obtain a report on all patients.

```
Select a patient: GIBSON,PAT         03-12-54     284627548    NO
EMPLOYEE

Select a patient: <RET>
One Moment Please...
DEVICE: [Enter a device name]
```

```
Patient:  GIBSON,PAT                  SSN: 284627548  DOB:   MAR 12,1954
------------------------------------------------------------------------------
                      [2]Self Report of Function Scores           |

           Date Recorded:  SEP  4,1996       Respondent Type:  PATIENT

Score Type:

Disposition:

          Move around inside house:  SOME HELP
                            Stairs:  TOTAL HELP OR NEVER DO
               Transfer to Bed/Chair:  SOME HELP
                  Transfer to Toilet:  SOME HELP
             Transfer to tub/shower:  EXTRA TIME OR SPECIAL TOOL
                            Eating:  EXTRA TIME OR SPECIAL TOOL
                          Grooming:  EXTRA TIME OR SPECIAL TOOL
                           Bathing:  EXTRA TIME OR SPECIAL TOOL
                Dressing upper body:  SOME HELP
                Dressing lower body:  EXTRA TIME OR SPECIAL TOOL
                          Toileting:  EXTRA TIME OR SPECIAL TOOL
                 Bladder management:  TOTAL HELP OR NEVER DO
                    Bowel Management:  TOTAL HELP OR NEVER DO

         Get to places outside of home:  UNABLE
                               Shopping:  UNABLE

        Planning and cooking own meals:  UNABLE
                        Doing housework:  UNABLE
                         Handling money:  WITH HELP

                    Help during last 2 weeks:    YES
  Number of hours of help in last 2 weeks:    70
 Number of hours of help in last 24 hours:    7

                 Method ambulation (Walking):  WITH DEVICE

              Method ambulation (Wheelchair):  MOTORIZED

                                     ----------
   Total Self Report of Function Score:  29.0
```

[1] Patch SPN*2.0*19 January 2003 – New report.
[2] Patch SPN*2.0*19 January 2003 – Updated display.

SCD Reports Menu...
Filtered Reports...

Utilization Reports...

Laboratory Utilization

This option produces a report of laboratory use by patients in your SCD registry over a selected date range.

```
Start date for period:  12/1/99  (DEC 01, 1999)
  End date for period:  (12/1/1999 - 12/29/1999): TODAY// <RET> (DEC 29,
1999)
Minimum number of results reported for a test to be listed:(1-999999):
3//<RET>


Number of highest users to identify:  (0-100): 0// 5
DEVICE: [Enter a device name]

Gathering patient data
```

```
                        SCD - Laboratory Utilization
                                SUPPORT ISC
                    For the Period 12/01/99 to 12/29/99

        Totals:  9 orders placed (75 results reported) for 1 patient
                   (These include 31 different lab tests)

   Patients     Orders

         1          9
```

```
                        SCD - Laboratory Utilization
                                SUPPORT ISC
                    For the Period 12/01/99 to 12/29/99

                      Lab Tests with 3 or more Results

                                                Max # Results
Lab Test                                Results      Patients      (#
patients)

CHLORIDE                                      4             1
CO2                                           4             1
CREATININE                                    4             1
GLUCOSE                                       4             1
POTASSIUM                                     4             1
SODIUM                                        4             1
UREA NITROGEN                                 4             1
HGB                                           3             1
```

SCD - Laboratory Utilization
SUPPORT ISC
For the Period 12/01/99 to 12/29/99

Different Patient Name	SSN	Orders	Results	Lab Tests
CAMPBELL,PATI	359-81-4444	9	75	31

SCD Reports Menu...
Filtered Reports...
Utilization Reports...

Laboratory Utilization (Specific)

This option produces specific lab utilization reports for patients in your SCD registry. You are prompted to enter a range of dates and laboratory test names to receive this report.

```
Start date for period:  1/1/99  (JAN 01, 1999)
  End date for period:  (1/1/1999 - 12/29/1999): TODAY// <RET>  (DEC 29,
1999)
Select LABORATORY TEST NAME: Creatinine
Another LABORATORY TEST NAME: <RET>


Do you want to see patient usage data?  YES// <RET>
DEVICE: [Enter a device name]

Gathering patient data
```

```
                  SCD - Laboratory Utilization (Specific)
                                SUPPORT ISC
                    For the Period 01/01/99 to 12/29/99

                                  CREATININE
Total:  1 patient                                          4

Patient Name                        SSN                 Tests

CAMPBELL,PATI                    359-81-4444               4
```

SCD Reports Menu...
Filtered Reports...
Utilization Reports...

Pharmacy Utilization

This option produces pharmacy utilization reports of patients in your SCD registry. You are prompted to enter a range of dates and how dollar costs should be reported.

```
Start date for period:  1/1/99  (JAN 01, 1999)
  End date for period:  (1/1/1999 - 12/29/1999): TODAY// <RET>  (DEC 29,
1999)
Minimum number of fills to display:  (1-999999): 2// <RET>
Minimum dollar cost of dispensed fills to display:  (0-9999999): 10// <RET>

     Select one of the following:

          1         Actual cost at the time
          2         Current cost today

How should dollar costs of prescription drugs be reported?: 1  Actual cost at
the time


Number of highest users to identify:  (0-100): 0// 5
DEVICE: [Enter a device name]

Gathering patient data
```

```
                  SCD - Pharmacy Prescription Utilization
                                SUPPORT ISC
                     For the Period 01/01/99 to 12/29/99

                 Totals:  50 fills reported for 6 patients
                     (These include 20 different drugs)

   Patients      Fills

         1         21
         3          7
         1          6
         1          2
```

SCD - Pharmacy Prescription Utilization
SUPPORT ISC
For the Period 01/01/99 to 12/29/99

Drugs with 2 or more fills

Drug	Fills	Patients	Max # Fills (# patients)
DIGOXIN 0.25MG TAB	7	3	3 (2)
DIGOXIN (LANOXIN) 0.125MG TAB	4	3	2 (1)
PROCAINAMIDE 500MG CAPSULE	4	3	2 (1)
GLYBURIDE 2.5MG TAB	4	2	2 (2)
ALBUTEROL INHALER 17GM	4	1	
BECLOMETHASONE INHALER 16.8GM	4	1	
LOVASTATIN 10MG TAB	3	2	2 (1)
WARFARIN 5MG TAB	3	2	2 (1)
DIAZEPAM 5MG TAB	3	1	
ASPIRIN 325MG TAB	2	1	
QUINIDINE SULFATE 200MG TAB	2	1	
TERFENADINE 60MG TABLET	2	1	

SCD - Pharmacy Prescription Utilization
SUPPORT ISC
For the Period 01/01/99 to 12/29/99

Drugs with fills totaling $10.00 or more

Drug	Actual Cost	Fills	Qty Disp	Pats
TERFENADINE 60MG TABLET	180.00	2	180	1
GLYBURIDE 2.5MG TAB	144.00	4	360	2
LOVASTATIN 10MG TAB	90.00	3	90	2
NEFAZODONE 100MG TABLET	50.01	1	30	1
DIAZEPAM 5MG TAB	31.95	3	90	1
DIGOXIN (LANOXIN) 0.125MG TAB	28.80	4	360	3
BECLOMETHASONE INHALER 16.8GM	24.18	4	6	1
NIFEDIPINE 10MG CAP	22.44	1	120	1
DIGOXIN 0.25MG TAB	20.85	7	510	3
ALBUTEROL INHALER 17GM	15.00	4	4	1
PROCAINAMIDE 500MG CAPSULE	12.00	4	480	3
TOTAL for listed drugs	619.23			
TOTAL (including unlisted drugs)	640.01			

SCD - Pharmacy Prescription Utilization
SUPPORT ISC
For the Period 01/01/99 to 12/29/99

Patients	Dollar Cost of Fills
1	300-399
2	100-199
3	0- 99

SCD - Pharmacy Prescription Utilization
SUPPORT ISC
For the Period 01/01/99 to 12/29/99

Highest Utilization Patients Based on Fills

Patient Name	SSN	Total Fills	Different Drugs	Total Cost
CANUSEE,PATI	444-22-6666	21	10	310.58
BIRD,PAT	342-56-9870	7	4	160.35
ARMSTRONG,PT	445-67-8989	7	4	118.41
BUREN VAN,PATIEN	345-66-0123	7	3	24.03
CAMPBELL,PATI	359-81-4444	6	6	22.41
BARNEY,PATIEN	332-45-6754	2	2	4.23

SCD - Pharmacy Prescription Utilization
SUPPORT ISC
For the Period 01/01/99 to 12/29/99

Highest Utilization Patients Based on Cost

Patient Name	SSN	Total Fills	Different Drugs	Total Cost
CANUSEE,PATI	444-22-6666	21	10	310.58
BIRD,PAT	342-56-9870	7	4	160.35
ARMSTRONG,PT	445-67-8989	7	4	118.41
BUREN VAN,PATIEN	345-66-0123	7	3	24.03
CAMPBELL,PATI	359-81-4444	6	6	22.41

SCD Reports Menu...
Filtered Reports...
Utilization Reports...

Pharmacy Utilization (Specific)

This option produces specific pharmacy utilization reports for patients in your SCD registry showing the dollar cost of prescriptions. You are prompted to enter a range of dates and to select a generic drug name.

```
Start date for period:  1/1/99  (JAN 01, 1999)
  End date for period:  (1/1/1999 - 12/29/1999): TODAY// <RET>  (DEC 29,
1999)
Select a GENERIC DRUG NAME: WARFARIN
     1   WARFARIN (COUMADIN) NA 2.5MG TAB           BL100
     2   WARFARIN 5MG TAB           BL100
CHOOSE 1-2: 2  WARFARIN 5MG TAB         BL100
Another GENERIC DRUG NAME: <RET>


Do you want to see patient usage data?  YES// <RET>
DEVICE: [Enter a device name]

Gathering patient data
```

```
                  SCD - Pharmacy Prescription Utilization
                                SUPPORT ISC
                    For the Period 01/01/99 to 12/29/99

                  WARFARIN 5MG TAB, currently $0.0360/unit
Total:  2 patients                                    3         90         $3.24

Patient Name                        SSN            Fills       Qty         Value

CAMPBELL, PATI                   359-81-4444           1         30          1.08
CANUSEE,PATI                     444-22-6666           2         60          2.16
```

SCD Reports Menu...
Filtered Reports...
Utilization Reports...

Radiology Utilization

This option produces a multi-part report showing the various completed radiology procedures and their associated costs (if the cost data is present) during the period specified.

Radiology personnel may also use this option. However, unless they possess the SPNL SCD PTS security key, they are not given the opportunity to see specific patients. This preserves patient confidentiality.

```
Start date for period:  1/1/99  (JAN 01, 1999)
  End date for period:  (1/1/1999 - 12/29/1999): TODAY// <RET>  (DEC 29,
1999)
Minimum number of procedures to display:  (1-99999): 2// 1
Minimum dollar cost of procedures to display:  (0-999): 10// <RET>


Number of highest users to identify:  (0-100): 0// 5
DEVICE: [Enter a device name]

Gathering patient data
```

```
                        SCD - Radiology Utilization
                                 SUPPORT ISC
                     For the Period 01/01/99 to 12/30/99

                 Totals:  8 procedures reported for 6 patients
                     (These include 8 different procedures)

   Patients  Procedures

          2           2
          4           1
```

```
                        SCD - Radiology Utilization
                                 SUPPORT ISC
                     For the Period 01/01/99 to 12/30/99

                              1 or More Procedures

Radiology Procedure                  CPT Code    Procedures    Value    Patients

ABDOMEN 2 VIEWS                        74010            1      $.$$          1
ANGIO BRACHIAL RETROGRADE CP           75659            1      $.$$          1
ANKLE 2 VIEWS                          73600            1      $.$$          1
CHEST 4 VIEWS                          71030            1      $.$$          1
CLAVICLE                               73000            1      $.$$          1
FOOT 3 OR MORE VIEWS                   73630            1      $.$$          1
HIP 1 VIEW                             73500            1      $.$$          1
KNEE 3 VIEWS                           73562            1      $.$$          1
```

SCD - Radiology Utilization
SUPPORT ISC
For the Period 01/01/99 to 12/30/99

Radiology procedures totaling $10.00 or more

Radiology Procedure	CPT Code	Value	Procedures	Patients
TOTAL for all procedures		$.$$		

SCD - Radiology Utilization
SUPPORT ISC
For the Period 01/01/99 to 12/30/99

Highest Utilization Patients Based on Number of Procedures

Patient Name	SSN	Total Procs	Different Procs	Total Value
BIRD,PAT	342-56-9870	2	2	$.$$
LIME,PATIE	389-38-9467	2	2	$.$$
SMITH,PATIEN	111-11-2043	1	1	$.$$
CANUSEE,PATI	444-22-6666	1	1	$.$$
CAMPBELL,PATI	359-81-4444	1	1	$.$$
HARPER,PAT	578-65-7687	1	1	$.$$

SCD - Radiology Utilization
SUPPORT ISC
For the Period 01/01/99 to 12/30/99

Highest Utilization Patients Based on Value

Patient Name	SSN	Total Procs	Different Procs	Total Value
BIRD,PAT	342-56-9870	2	2	$.$$
LIME,PATIE	389-38-9467	2	2	$.$$
SMITH,PATIEN	111-11-2043	1	1	$.$$
CANUSEE,PATI	444-22-6666	1	1	$.$$
CAMPBELL,PATI	359-81-4444	1	1	$.$$
HARPER,PAT	578-65-7687	1	1	$.$$

SCD Reports Menu...

Functional Status Scores

This option prints a patient's functional status scores for either the [1]Self Report of Function or FIM.

```
     Select one of the following:

          1         Self Report of Function
          2         FIM

Select the type of Functional Status you wish to print:1  Self Report of
Function


Enter the beginning date range: T-14
Enter the ending    date range: T

Select PATIENT: CAMPBELL,PATI           01-02-50     359814444     NO
PILL

 Enrollment Priority: GROUP 5           Category: IN PROCESS    End Date:


Another one: <RET>

DEVICE: [Enter a device name]
```

```
                    [2]Self Report of Function Total Score        Page: 1
                                for CAMPBELL,PATI                    Dec 30, 1999
                           SSN: 359814444, DOB: JAN 02, 1950
          Extent & Completeness: TETRAPLEGIA - COMPLETE SENSORY AND MOTOR
                             Type of Injury: INDETERMINATE

DATE      SCORE     A  B  C  D  E  F  G  H  I  J  K  L  M  N  O  P  Q  R
-------------------------------------------------------------------------

12/17/99   29.0     3  3  2  2  2  2  2  2  2  2  2  2  3

A-EATING                G-BLADDER MANAGEMENT              M-STAIRS
B-GROOMING              H-BOWEL MANAGEMENT                N-COMPREHENSION
C-BATHING               I-TRANSFER TO BED/CHAIR           O-EXPRESSION
D-DRESSING UPPER BODY   J-TRANSFER TO TOILET              P-SOCIAL INTERACTION
E-DRESSING LOWER BODY   K-TRANSFER TO TUB/SHOWER          Q-PROBLEM SOLVING
F-TOILETING             L-MOVE AROUND INSIDE YOUR HOUSE   R-MEMORY
  Star "*" indicates the score is incomplete.
```

[1] Patch SPN*2.0*19 January 2003 – New Report
[2] Patch SPN*2.0*19 January 2003 – Updated display.

ICD9 Code Search

This option allows users to find patients in or out of the SCD Registry who have just one particular ICD9 code, have several particular ICD9 codes, or fall in a range of ICD9 codes. The report searches the patients in the PTF file (#45) according to user-specified admission dates, and will include patients who have any of the ICD9 codes

```
Select SCD Reports Menu Option: ICD  ICD9 Code Search

Do you want patients in the Registry only? Yes// Y  (Yes)
Would you like to sort on a Range of ICD9 codes? No// Y  (Yes)
Starting ICD9 Code: 192.2  192.2     MAL NEO SPINAL CORD     COMPLICATION/COMORY
         ...OK? Yes// <RET>  (Yes)

Ending ICD9 code: 952.16  952.16     COMPLETE LES CORD/T7-T12     COMPLICATION/Y
         ...OK? Yes// <RET>  (Yes)

Enter an Admission STARTING date: JAN 19,2001//010101  (JAN 01, 2001)
Enter an Admission ENDING date: JAN 16,2001//013101  (JAN 31, 2001)
Select DEVICE: HOME// <RET>  VIRTUAL/CURRENT DEVICE

                  Patients in the Registry only
                            ICD9 Code Search                          Page: 1
          Ran on admissions from JAN 1,2001 to JAN 31,2001@23:59


Patient                        SSN              Registration Status      SCI Level
Admission Date
------------------------------------------------------------------------------
MARCUS,MARK D                  000001212 SCD - CURRENTLY SERVED   C05
Admission: JAN 03, 2001@21:12:28
DXLS: 996.31  ICD2: 427.31  ICD3: 427.32  ICD4: 344.00  ICD5: 907.2
ICD6:         ICD7:         ICD8:         ICD9:         ICD10:
------------------------------------------------------------------------------
BENEATH,JAMES M                562000003 SCD - CURRENTLY SERVED   L03
Admission: JAN 05, 2001@16:15
DXLS: V58.49  ICD2: 239.4   ICD3: 344.1   ICD4: 907.2   ICD5:
ICD6:         ICD7:         ICD8:         ICD9:         ICD10:
------------------------------------------------------------------------------
PERKY,BILLY BOB C               120000089 SCD - CURRENTLY SERVED
Admission: JAN 24, 2001@23:08:58
DXLS: 340.    ICD2: 599.0   ICD3: 041.04  ICD4: V09.0   ICD5: 041.3
ICD6: 288.0   ICD7: 596.54  ICD8: 446.5   ICD9: 401.9   ICD10:
------------------------------------------------------------------------------
```

SCD Reports Menu...

Print MS Help Text

This option prints or displays the Multiple Sclerosis help.

```
Display expanded Multiple Sclerosis descriptions

Select DEVICE: HOME// (Press the <RET> key or enter a device name.)


          MS Expanded Help Text                   Page: 1   MAY 31,2000
------------------------------------------------------------------------------
--
   PYRAMIDAL
   =========
Normal
Abnormal Signs without disability.
Minimal disability.
Mild to moderate paraparesis or hemiparesis; severe monoparesis.
Marked paraparesis or hemiparesis; moderate quadriparesis, or
   monoplegia.
Paraplegia, hemiplegia, or marked quadriparesis.
Quadriplegia.
Unknown

   BRAINSTEM
   =========
Normal
Signs only.
Moderate nystagmus or other mild disability.
Severe nystagmus, marked extraocular weakness.
Marked dysarthria.
Inability to swallow or speak.
Unknown

   SENSORY
   =======
Normal
Vibration or finger-writing decrease only, in 1 or 2 limbs.
Mild decrease in touch or pain or position sense, and/or
   moderate decrease in vibration in 1 or 2 limbs or vibration
   decrease alone in 3 or 4 limbs.
Moderate decrease in touch or pain or position sense, and/or
   essentially lost vibration in 1 or 2 limbs; mild decrease in
   touch or pain and/or moderate decrease in all proprioceptive
   tests in 3 or 4 limbs.
Marked decrease in touch or pain or loss of proprioception, alone
   or combined, in 1 or 2 limbs; or moderate decrease in touch or
   pain and/or severe proprioception decrease in more than 2 limbs.
Sensation essentially lost below head.
Unknown
```

```
   CEREBRAL
   ========
Normal
Mood alteration only.
Mild decrease in mentation.
Moderate decrease in mentation.
Marked decrease in mentation.
Dementia or chronic brain syndrome.
Unknown

   CEREBELLAR
   ==========
Normal
Abnormal signs without disability.
Mild ataxia.
Moderate truncal or limb ataxia (tremor or clumsy movements
   interfere with function in all spheres).
Severe ataxia in all limbs (most function is very difficult).
Unable to perform coordinated movements due to ataxia.
Weakness (grade 3 or more on pyramidal) interferes with testing.
Unknown

   BOWEL & BLADDER
   ===============
Normal
Mild hesitancy.
Moderate hesitance, urgency, retention or rare incontinence
   (intermittent self-catheterization, manual compression to
   evacuate bladder or finger evacuation of stool).
Frequent urinary incontinence.
In need of almost constant catheterization (and constant use of
    measure to evacuate stool).
Loss of bladder function.
Loss of bladder and bowel function.
Unknown

   VISUAL
   ======
Normal
Scotoma with visual acuity (corrected) better than 20/30.
Worse eye with scotoma with maximum visual acuity (corrected) or
   20/30 to 20/59.
Worse eye with large scotoma, or moderate decrease in fields, but
   with maximal visual acuity of 20/60 to 20/99.
Worse eye with marked decrease of fields and maximal visual acuity
   (corrected) of 20/100 to 20/200; grade 3 plus maximal acuity
   better eye 20/60 or less.
Worse eye with  maximal visual acuity or (corrected) less than
   20/20; grade 4 plus maximal acuity of better eye 20/60 or less.
Grade 5 plus maximal visual acuity of better eye 20/60 or less.
Presence of temporal pallor.
Unknown
```

OTHER
=====
None
Any other neurological finding attributed to MS.
Unknown

EDSS
====
Normal neurological exam.
No disability, minimal signs in one FS.
No disability, minimal signs in more than one FS.
Minimal disability in one FS.
Minimal disability on two FS.
Moderate disability in one FS.
Fully ambulatory but with moderate disability in one FS and one or two FSs grade 2; or two FSs grade 3; or five FSs grade 2.
Fully ambulatory without aid, self-sufficient, up and about some 12 hrs despite relatively severe disability consisting of one FS grade 4, or combinations of lesser grades exceeding limits of previous steps.
Fully ambulatory without aid up and about much of the day, able to work full day may otherwise have some limitations of full activity or require minimal assistance.
Ambulatory without aid or rest for about 200 meters, disability severe enough to impair full daily activity.
Ambulatory without aid or rest for about 100 meters, disability severe enough to preclude full daily activity.
Intermittent or unilateral constraint assistance (cane, crutch, brace) required to walk about 100 meters with or without resting.
Constant bilateral assistant (cane, crutches, brace) required to walk about 20 meters without resting.
Unable to walk beyond about 5 meters even with aid; essentially restricted to wheelchair, wheels self in standard wheelchair and transfers alone; up and about in wheelchair some 12 hours a day.
Unable to take more than a few steps; restricted to wheelchair; may need aid in transfer; wheels self, but cannot carry on in standard wheelchair a full day; may require motorized wheelchair.
Essentially restricted to bed or chair or perambulated in wheelchair, but may be out of bed himself/herself much of the day; retains many self-care functions; generally has effective use of arms.
Essentially restricted to bed much of the day; has some effective use of arms; retains some self-care functions.
Helpless bed patient; can communicate and eat.
Totally helpless bed patient; unable to communicate effectively or eat/swallow.
Death due to MS

SCD Reports Menu...

MS (Kurtzke) Measures

This option allows you to produce an MS (Kurtzke) Measures report (functional system) on selected patients. You have the option of choosing all patients or entering specific patients as illustrated below. This report will result in an EDSS (Expanded Disability Status Scale) score. To select all patients, enter ALL at the "Select a patient" prompt.

```
Select a patient: GIBSON,PATIENT         03-12-54     284627548    NO
EMPLOYEE

Select a patient: <RET>
One Moment Please...
DEVICE: [Enter a device name]
```

```
Patient:  GIBSON,PATIENT               SSN: 284627548  DOB:   MAR 12,1954
------------------------------------------------------------------------------
                          Date Recorded:  SEP  4,1996

                          Functional System (Kurtzke)
 Pyramidal:   3 Mild-mod para or hemiparesis
 Brainstem:   3 Sev nystag, mark extraocular
   Sensory:   5 Sensation essentially lost b
  Cerebral:   5 Dementia or chronic brain sy
Cerebellar:   1 Abnormal signs without disab
BWL & BLDR:   2 Mod hes, urg, ret, rare inco
    Visual:   3 Worse eye large scotoma, \|/
     Other:

                Expanded Disability Status Scale (EDSS/Kurtzke)

EDSS Score:
4.5  1 FS grade 4; walk without aid or rest 300 m
```

SCD Reports Menu...

MS Patient Listing

Use this option to obtain a list of Multiple Sclerosis patients. You can filter out patients you don't want on the list. Your selection choices are shown in the example.

```
     Select one of the following:

          A         ALL
          0         NOT SCD
          1         SCD - CURRENTLY SERVED
          2         SCD - NOT CURRENTLY SERVED
          X         EXPIRED

Select a Registration Status: A// 1  SCD - CURRENTLY SERVED

     Select one of the following:

          A         ALL
          Y         SCI NETWORK YES
          N         SCI NETWORK NO

Select a SCI NETWORK: A// <RET>LL

     Select one of the following:

          A         ALL
          UN        UNKNOWN
          RR        RELAPSING-REMITTING
          PP        PRIMARY PROGRESSIVE
          SP        SECONDARY PROGRESSIVE
          PR        PROGRESSIVE RELAPSING

Select a MS Subtype value: A// <RET>LL
Select DEVICE: HOME//   (Press the <RET> key or select a printer.)
```

```
                      MS Patient Listing Report     MAY 31,2000    Page: 1
Patient                  SSN            MS Subtype                Provider
(Last / Next Eval)              Date of Onset            (EDSS Date & Score)
--------------------------------------------------------------------------------
BIRD,K G                 342569870      RELAPSING-REMITTING
WILLIAMSON,CAT
(             )                 FEB 3,1987               (  )
--------------------------------------------------------------------------------
BUREN VAN,MARTIN         345660123      PRIMARY PROGRESSIVE
WILLIAMSON,CAT
(JAN 07, 1999 JAN 07, 2000)      MAY 6,1989               (  )
--------------------------------------------------------------------------------
MATISSE,HENRI            567879123      RELAPSING-REMITTING       BALL,KEN
(FEB 02, 1999 FEB 02, 2000)      JUN 7,1989               (  )
--------------------------------------------------------------------------------
```

SCD Reports Menu...

Patient Summary Report

This option allows you to print the contents of a patient's SCD record.

```
Select PATIENT: CAMPBELL,PATI           01-02-50     359814444     NO
PILL

 Enrollment Priority:            Category: IN PROCESS    End Date:


Another one: <RET>

DEVICE: [Enter a device name]
```

```
Patient: CAMPBELL,PATI                  SSN: 359814444            DOB: 01/02/1950
Registration Status: NOT SCD                 Registration Date: 04/07/1998
VA SCI Status:  QUADRIPLEGIA-NONTRAUMATIC
SCI    Level: T02                            Extent of SCI:  COMPLETE
Last Annual   Rehab Received:
BCR Care Remb: YES   BCR Date Cert:..04/04/1999      BCR Provider: KELLY,MARC
MS Subtype:   RELAPSING-REMITTING
Date of Last Update: 05/11/2000         Last Update By: MILES,CHRIS

      Date ofOnset    Etiology                      Type of Cause
      ============    ========                      =========
      10/02/99        MULTIPLE SCLEROSIS            NON-TRAUM
```

SCD Reports Menu...

Show Sites Where Patient has been Treated

Use this option to view/print the facilities (other VA sites) where a patient has been treated. This information is derived from the Treating Facility List file (#391.91) and requires the installation of CIRN (Clinical Information Resource Network).

```
Select SCD (SPINAL CORD) REGISTRY PATIENT: TEST,PATIENT           11-7-55
0
Enrollment Priority: GROUP 5    Category: IN PROCESS    End Date:


Pt Has Been Treated at              Date Last Treated

DENVER, CO                          03/28/2000
HAMPTON, VA.                        02/13/2000
```

Change your Division Assignment

When you first access the Spinal Cord Dysfunction program, your division assignment is displayed.

```
     Hello <Your Name>
     You are working under the division of <Division Number> / <Division
Name>
```

Use this option to change the division.

[1]Inquire to an Outcome

This option is used to view completed data fields for a particular Outcome record.

```
PATIENT: DAVIDSON, HARLEY                    RECORD TYPE: ASIA
  DATE RECORDED: JUL 19, 2001                       DISPOSITION: 3 HOME ASSISTED
  ASIA IMPAIRMENT SCALE: A                          ASIA HIGHEST NEURO LEVEL: T04
  SSN (c): 496016821                                             DOB (c): MAY 25,1919
  AGE (c): 77                                                          MOTOR SCORE (c):
ERROR
  COGNITIVE SCORE (c): ERROR                        TOTAL SCORE (c): ERROR
  CHART TOTAL SCORE (c): 0                          LENGTH OF REHAB IN DAYS (c): 0
  DATE OF DEATH (c): DEC 10,1996@11:02
```

[1] Patch SPN*2.0*19 January 2003 – New Option, text, and display.

[1]Edit Non-conforming Outcome

This option is used to edit older outcome records, i.e., those outcomes that were on file prior to the adoption of the "episode of care" clinical model, introduced in patch SPN*2*19. Accordingly, this option is restricted to only those records.

This edit option is limited to OLDER outcomes only, i.e., outcomes on file before the adoption of the 'episode of care' clinical model. Editing an older outcome record will not convert it to the new model. This option is not intended for regular use, but does provide a way to access older, heritage outcomes to correct data inaccuracies.

```
Patient: DAVIDSON, HARLEY    SSN: 496-01-6821
Record Type: ASIA      Date Recorded: 07/19/2001
------------------------------------------------------------------------

DISPOSITION: 3 HOME ASSISTED//
ASIA IMPAIRMENT SCALE: A//
TOTAL MOTOR SCORE:
TOTAL PIN PRICK SCORE:
TOTAL LIGHT TOUCH SCORE:
NEUROLEVEL-SENSORY RIGHT:
NEUROLEVEL-SENSORY LEFT:
NEUROLEVEL-MOTOR RIGHT:
NEUROLEVEL-MOTOR LEFT:
ASIA COMPLETE/INCOMPLETE:
PARTIAL PRESERVATION-SENSORY R:
PARTIAL PRESERVATION-SENSORY L:
PARTIAL PRESERVATION-MOTOR R:
PARTIAL PRESERVATION-MOTOR L:
ASIA HIGHEST NEURO LEVEL: T04//
```

[1] Patch SPN*2.0*19 January 2003 – New Option, text, and display.

SCD Package Management Functions

The following options are utilities that Systems Managers can use to set up and maintain the SCD package. The SCD Package Management Menu is locked with the SPNL SCD MGT security key. This security key is required to edit your SCD Site Parameters file (#154.91). It should be given to the SCI Coordinator and/or IRM Support person.

SCD Package Management Menu...
- Edit Site Parameters
- Activate an SCD Registrant
- Delete an Outcome Record
- Delete Registry Record
- Enter/Edit Etiology SYNONYM
- Inactivate an SCD Registrant

SCD Package Management Menu...

Edit Site Parameters

The SCD Site Parameters file (#154.91) controls the duration of time for follow up reporting and the admission/discharge notice system.

Follow up Reporting

F/U RPT (LAST SEEN) PERIOD
F/U RPT (LAST PHY EXAM) PERIOD
Enter duration of time during which patients have not been seen at your facility for reporting purposes. Both of these fields have default of 180 days. These fields are used for the reports: Follow-Up (Last Seen) and Follow-Up (Last Annual Rehab Eval Received).

Admission/Discharge Notice System

If your site wants to be able to notify a specific group when patients with SCI or MS are admitted or discharged, then mail groups should be created for that purpose and members added prior to setting the parameters for SCI Notification Mail Group and MS Notification Mail Group. If the people for the groups are the same, you may want to consider creating just one group and using it for both types of notifications.

SEND NOTIFICATION
Enter YES to notify a mail group that a patient with SCI (Spinal Cord Injury) or MS (Multiple Sclerosis) has been admitted or discharged, NO to suppress notifications. The message will be sent to the mail group for the site parameter SCI Notification Mail Group or MS Notification Mail Group depending on whether the patient is MS or SCI.

SCI NOTIFICATION MAIL GROUP
The default for this is the SPNL SCD Coordinator mail group. If your site created a specific mail group and you want that group to receive these notifications, then enter it here.

MS NOTIFICATION MAIL GROUP
The default for this is the SPNL SCD Coordinator mail group. If your site created a specific mail group and you want that group to receive these notifications, then enter it here.

The Facility Number cannot be edited directly through the Edit Site Parameters option. It is automatically updated from the Kernel Site Parameters file (#4.3) every time you execute this option. Updating the Kernel Site Parameters file can only make changes to the Facility Number.

```
Select SCD Package Management Menu Option: Edit Site Parameters
```

```
F/U RPT (LAST SEEN) PERIOD: 180D// ??
This is the period which the Follow Up (Last Seen) report uses. Patients
who haven't been seen for this period of time will be displayed in the
report. The default may be changed through the Site Parameters menu.
For example, 180D is 180 days; 6M is 6 months.
F/U RPT (LAST SEEN) PERIOD: 180D// <RET>
F/U RPT (LAST PHY EXAM) PERIOD: 180D// ??
This is the period, which the Follow Up (Last Physical Exam) report uses.
Patients who haven't had a physical exam for this period of time will be
displayed in the report. The default may be changed through the Site
Parameters menu. For example, 180D is 180 days; 6M is 6 months.
F/U RPT (LAST PHY EXAM) PERIOD: 180D// <RET>
SEND NOTIFICATION: YES// <RET>
SCI NOTIFICATION MAIL GROUP: SPNL SCD COORDINATOR// SPNL SCI
MS NOTIFICATION MAIL GROUP: SPNL SCD COORDINATOR// SPNL MS
```

SCD Package Management Menu...

Activate an SCD Registrant

You may use this option to reactivate a record that has been inactivated in your local SCD registry. (Even though the record was inactivated, it was not deleted from VISTA.) After responding YES to the "Are you sure…" prompt, the patient is automatically activated in the local registry.

You can inactivate an active record by one of two methods: by using the option Inactivate an SCD Registrant or by resetting the REGISTRATION STATUS to SCD - NOT CURRENTLY SERVED in the Registration and Health Care Information option.

```
Select SCD Package Management Menu Option: Activate an SCD Registrant

Select PATIENT: DOE,MARY 02-02-22 222333444 NO EMPLOYEE
Are you sure you want DOE,MARY active? NO// Y YES
DOE, MARY is now active.
```

SCD Package Management Menu...

Delete an Outcome Record

If you entered a record in error, you can remove it from the database by using this option. This option deletes only the outcomes record.

Anytime you delete a record, a mail message is sent to the SPNL SCD Coordinator mail group informing the members of the deletion.

Select SCD Package Management Menu Option: **Delete an Outcome Record**

```
Select Outome Record to Delete: CATT,FELIX         08-08-63     666770000
YES     MILITARY RETIREE
     1                      666770000   CLINICIAN REPORTED  JUN 21, 1995
     2                      666770000   CLINICIAN REPORTED  MAR 23, 1995
     3                      666770000   FOUR LEVEL FUNCTIO  JUN 23, 1994
     4                      666770000   CLINICIAN REPORTED  SEP 12, 1995
     5                      666770000   FOUR LEVEL FUNCTIO  DEC 08, 1995
TYPE '^' TO STOP, OR <RET>
CHOOSE 1-5: 2

OK to delete this record: No// YES

Select Outcome Record to Delete: <RET>

Sending deletion notification to the SPNL SCD COORDINATOR mail group...
          DOWART,DON L.
```

SCD Package Management Menu...

Delete Registry Record

If you entered a record in error, you can remove it from the database by using this option. This option deletes only the registry record.

Anytime you delete a record, a mail message is sent to the SPNL SCD COORDINATOR mail group informing the members of the deletion.

```
Select SCD Package Management Menu Option: Delete Registry Record

Select Registry Record to Delete: FITZ,OLLIE         11-14-15     613241415
YES     SC VETERAN      613241415

OK to delete this record: No// YES

Select Registry Record to Delete: <RET>

Sending deletion notification to the SPNL SCD COORDINATOR mail group...
          DOWART,DON L.
```

SCD Package Management Menu...

Enter/Edit Etiology SYNONYM

This option allows you to enter/edit the cause of a spinal cord dysfunction. As shown in the prompts and responses below, you may enter the number of the etiology, description (first few letters of entry), type of cause (traumatic or non-traumatic), or one or more synonyms.

```
Select SCD Package Management Menu Option: Enter/Edit Etiology SYNONYM

Select ETIOLOGY (Cause of SCD):  ?
 Answer with ETIOLOGY NUMBER, or DESCRIPTION, or TYPE OF CAUSE, or
     SYNONYM
 Do you want the entire 16-Entry ETIOLOGY List? Y  (Yes)
Choose from:
   1               SPORTS ACTIVITY      TRAUMATIC CAUSE
   2               ACT OF VIOLENCE      TRAUMATIC CAUSE
   3               VEHICULAR            TRAUMATIC CAUSE
   4               FALL                 TRAUMATIC CAUSE
   5               INFECTION OR ABSCESS NON-TRAUMATIC CAUSE
   6               OTHER - TRAUMATIC    TRAUMATIC CAUSE
   7               MOTOR NEURON DISEASE NON-TRAUMATIC CAUSE
   8               MULTIPLE SCLEROSIS   NON-TRAUMATIC CAUSE
   9               TUMOR                NON-TRAUMATIC CAUSE
   10              OTHER                UNKNOWN
   11              OTHER - DISEASE      NON-TRAUMATIC CAUSE
   12              POLIOMYELITIS        NON-TRAUMATIC CAUSE
   13              UNKNOWN              NON-TRAUMATIC CAUSE
   14              UNKNOWN              TRAUMATIC CAUSE
   15              SYRINGOMYELIA        NON-TRAUMATIC CAUSE
   16              ARTHRITIC DISEASE OF THE SPINE      NON-TRAUMATIC CAUSE

Select ETIOLOGY (Cause of SCD):  8  MULTIPLE SCLEROSIS        NON-TRAUMATIC
CAUSE
```

```
                        ETIOLOGY: MULTIPLE SCLEROSIS
                      TYPE OF CAUSE: NON-TRAUMATIC CAUSE
_____________________________________________________________________________


    Select Etiology SYNONYM: MS
                             NEUROLOGICAL DIS OF SPINE & BRAIN

_____________________________________________________________________________
  Are you adding 'NEUROLOGICAL DIS OF SPINE & BRAIN' as a new SYNONYM (the
2ND for this ETIOLOGY)? Y

Save changes before leaving form (Y/N)? Y

COMMAND: E                                  Press <PF1>H for help    Insert
```

Inactivate an SCD Registrant

This option gives you the ability to inactivate a patient in your local registry. Use this option when the patient is not expected to return to your facility or in the case of the patient's death.

After entering a patient's name and responding YES to the "Are you sure..." prompt, the patient is automatically inactivated in the local registry.

You can activate an inactive record by one of two methods: by using the option Activate an SCD Registrant or by resetting the REGISTRATION STATUS field to SCD -CURRENTLY SERVED in the Registration and Health Care Information option.

```
Select SCD Package Management Menu Option: Inactivate an SCD Registrant

Select PATIENT: DOE,MARY 02-02-22 222333444 NO EMPLOYEE

Are you sure you want DOE,MARY inactive? NO// YES
DOE,MARY is now inactive.
```

Appendix A – National SCD Registry Data Transmission

All fields in the SCD (Spinal Cord) Registry file (#154) and the Outcomes file (#154.1) are transmitted to the National Spinal Cord Dysfunction Registry. This process is performed through the use of HL7.

Adding or editing a record triggers the transmission process:

Whenever a patient's record is added or edited, an HL7 message is generated and sent to the Q-SCD.MED.VA.GOV domain. This domain is located at the Austin Automation Center in Austin Texas. Once there, the data is placed into a comprehensive National SCD database. This information will be used for national reports and trending of Spinal Cord Injury patients.

No extra steps need to be performed to trigger this event. There will be no outward indication informing you that this process is occurring.

Appendix B – Levels of Injuries & Etiologic Origins

Category List of SCD Neurological Levels Of Injuries

The following is a list of possible Neurological Levels Of Injuries associated with a spinal cord dysfunction. The field name, which holds the patient's data, is called "SCI LEVEL".

C01	CERVICAL	01
C02	CERVICAL	02
C03	CERVICAL	03
C04	CERVICAL	04
C05	CERVICAL	05
C06	CERVICAL	06
C07	CERVICAL	07
C08	CERVICAL	08
L01	LUMBAR	01
L02	LUMBAR	02
L03	LUMBAR	03
L04	LUMBAR	04
L05	LUMBAR	05
S01	SACRAL	01
S02	SACRAL	02
S03	SACRAL	03
S04	SACRAL	04
S05	SACRAL	05
T01	THORACIC	01
T02	THORACIC	02
T03	THORACIC	03
T04	THORACIC	04
T05	THORACIC	05
T06	THORACIC	06
T07	THORACIC	07
T08	THORACIC	08
T09	THORACIC	09
T10	THORACIC	10
T11	THORACIC	11
T12	THORACIC	12
UNK	UNKNOWN	

Category List of SCD Etiologic Origins

The following is a list of possible etiologic origins associated with a spinal cord dysfunction.

Act of Violence	Traumatic Cause
Arthritic Disease of the Spine	Non-Traumatic Cause
Fall	Traumatic Cause
Infection or Abscess	Non-Traumatic Cause
Motor Neuron Disease	Non-Traumatic Cause
Multiple Sclerosis	Non-Traumatic Cause
Other	Unknown
Other - Disease	Non-Traumatic Cause
Other - Traumatic	Traumatic Cause
Poliomyelitis	Non-Traumatic Cause
Sports Activity	Traumatic Cause
Syringomyelia	Non-Traumatic Cause
Tumor	Non-Traumatic Cause
Unknown	Non-Traumatic Cause
Unknown	Traumatic Cause
Vehicular	Traumatic Cause

Appendix C – Using Ad Hoc Reports

Creating Simple Reports

The Ad Hoc Reports functionality lets you design your own reports using information from either the patient's outcomes (SCD Ad Hoc Report for Outcomes option) or the patient's registry data (SCD Ad Hoc Report for Registry option). In this appendix, we will use the SCD Ad Hoc Report for Registry option to show how reports are built using the ad hoc functionality.

Here is a simple report showing patients with evaluations due. Note that the sort criterion does not include free text and word processing fields (unnumbered selections). Also, all selections can be made at the first selection prompt with each selection separated by a comma. Comments are *italicized*.

Selecting Sort Fields:

```
================ Registration Ad Hoc Report Generator ================

 1 Patient              21 Describe Other          41 Annual Eval Received
 2 SSN                  22 Onset by Trauma         42 Next Annual Eval Due
 3 Date of Birth        23 MS Subtype              43 Last Annual Eval Offered
 4 Date of Death        24 Had Brain Injury?       44 Last Annual Eval Received
 5 Age                  25 Had Amputation?         45 Last Annual Eval Due
 6 Registration Date    26 Memory/Think Affected   46 Primary Care Provider
 7 Registration Status  27 Eyes Affected           47 SCD-Registry Coordinator
 8 Date of Last Update  28 One Arm Affected        48 Referral Source
 9 Last Updated By      29 One Leg Affected        49 Referral VA
10 Division             30 Both Arms Affected      50 Initial Rehab Site
11 SCI Network          31 Both Legs Affected      51 Init Rehab Discharge Date
12 SCI Level            32 Other Body Prt Affected 52 Bowel Care Reimbursement
13 VA SCI Status        33 Descr Other Body Part   53 BCR Date Certified
14 [1]Amount VA is Used  34 Extent of Movement      54 BCR Provider
15 Primary Care VAMC    35 Extent of Feeling       55 Sensory/Motor Loss
16 Annual Rehab VAMC    36 Bowel Affected          56 Class of Paralysis
17 Additional Care VAMC 37 Bladder Affected        57 Type of Injury
18 Non-VA Care          38 Remarks                 58 Enrollment Priority
19 Etiology             39 Extent of SCI
20 Date of Onset        40 Annual Eval Offered

   Sort selection # 1:
Sort selection # 1: 42,46            [Selections are separated by commas. Only 4
                                      sort fields are allowed.]

   Sort by: Next Annual Rehab Eval Due
    Sort from: BEGINNING// 1/1/2000  (JAN 01, 2000)

     Sort to:   ENDING// 1/31/2000  (JAN 31, 2000)

   Sort by: Primary Care Provider

     Sort from: BEGINNING// <RET>
```

[1] Patch SPN*2.0*19 January 2003– Revised field selection (fields 14, 47, & 58).

Selecting Print Fields:

```
================ Registration Ad Hoc Report Generator ================

 1 Patient              21 Describe Other         41 Annual Eval Received
 2 SSN                  22 Onset by Trauma        42 Next Annual Eval Due
 3 Date of Birth        23 MS Subtype             43 Last Annual Eval Offered
 4 Date of Death        24 Had Brain Injury?      44 Last Annual Eval Received
 5 Age                  25 Had Amputation?        45 Last Annual Eval Due
 6 Registration Date    26 Memory/Think Affected  46 Primary Care Provider
 7 Registration Status  27 Eyes Affected          47 SCD-Registry Coordinator
 8 Date of Last Update  28 One Arm Affected       48 Referral Source
 9 Last Updated By      29 One Leg Affected       49 Referral VA
10 Division             30 Both Arms Affected     50 Initial Rehab Site
11 SCI Network          31 Both Legs Affected     51 Init Rehab Discharge Date
12 SCI Level            32 Other Body Prt Affected52 Bowel Care Reimbursement
13 VA SCI Status        33 Descr Other Body Part  53 BCR Date Certified
14 [1]Amount VA is Used  34 Extent of Movement     54 BCR Provider
15 Primary Care VAMC    35 Extent of Feeling      55 Sensory/Motor Loss
16 Annual Rehab VAMC    36 Bowel Affected         56 Class of Paralysis
17 Additional Care VAMC 37 Bladder Affected       57 Type of Injury
18 Non-VA Care          38 Remarks                58 Enrollment Priority
19 Etiology             39 Extent of SCI
20 Date of Onset        40 Annual Eval Offered

   Print selection # 1: 1,2,3,12,19,38     [Selections are separated by commas.
                                           Only 7 print fields are allowed]

   Enter special report header, if desired (maximum of 60 characters).
 <RET>

   Include the sort criteria in the header? No// y  (Yes)
Do not queue this report if you used up-front or user selectable filters.

DEVICE: [Enter a device name]
```

[1] Patch SPN*2.0*19 January 2003 – Revised field selection (fields 14, 47, & 58).

```
SCD (SPINAL CORD) REGISTRY SEARCH              DEC 28,1999  11:12    PAGE 1
Sort Criteria: NEXT ANNUAL REHAB EVAL DUE from Jan 1,2000 to Jan
31,2000@24:00
               PRIMARY CARE PROVIDER not null
                                                 Date Of
Patient                            SSN           Birth
    Etiology                           SCI LEVEL
  Remarks
--------------------------------------------------------------------------------

        Next Annual Rehab Eval Due: JAN  3,2000
           Primary Care Provider: WILLIAMSON,CATHY
HARPER,PAT                         578657687   FEB  6,1941
    ARTHRITIC DISEASE OF THE SPINE  T03
  these are the remarks for this patient.
        Next Annual Rehab Eval Due: JAN  4,2000
           Primary Care Provider: WILLIAMS,MURRAY  S
LIME,PATIE                         389389467   DEC 12,1912
    FALL                               L04
  these are the remarks for this patient.
        Next Annual Rehab Eval Due: JAN  5,2000
           Primary Care Provider: WILLIAMS,MURRAY  S
CANUSEE,PATI                       444226666   APR  4,1932
    ARTHRITIC DISEASE OF THE SPINE  L05

        Next Annual Rehab Eval Due: JAN  7,2000
           Primary Care Provider: WILLIAMSON,CATHY
BUREN VAN,PATIEN                   345660123   OCT  1,1975
    MULTIPLE SCLEROSIS                 L05
  these are the remarks for this patient.
        Next Annual Rehab Eval Due: JAN 10,2000
           Primary Care Provider: BALL,KEN R
ARMSTRONG,PA                       445678989   JAN  1,1960
    ACT OF VIOLENCE                    C05
  These are the remarks for this patient.
```

All the print field headers (bolded) appear above the "----" line.
The Next Annual Rehab Eval Due and the Primary Care Provider sort field sub-headers are shown (bolded) below the "----" line.

The above report is okay but not particularly easy to read. You can use Sort and Print prefixes and suffixes to affect the appearance of the report.

Sort Prefixes

#	new page for each new value of the specified field.
-	sort field values in reverse order. (numeric & date/time fields only)
+	print subtotals for specified field totals. (Requires a print modifier to complete it's function)
!	give sequential number to each new value within specified field.
@	suppress sub-headers for specified field.
'	range without sorting.

Sort Suffixes

Sort suffixes all begin with a ";".

;Cn start the sub-header caption at a specified column number.

;Ln sort by the first 'n' characters of the value of the sort field.

;Sn skip 'n' lines every time the value of the sort field changes. You may use ;S to skip a single line (equivalent to ;S1)

;"xxx" use 'xxx' as the sub-header captions. You may use ;"" if not sub-header captions is desired.

;TXT force digits to be sorted as strings not as numbers.

Print Prefixes

& print totals for the field.

! print a count of the field.

+ print totals, counts, and mean for the field.

print totals, count, mean, maximum, minimum and standard deviation for the field.

Print Suffixes

;Cn	start the output for the selected field in column 'n'.
;Dn	round numeric fields to 'n' decimal places.
;Ln	left justify data in a field of 'n' characters. If the data is more than 'n' characters in length, it will be truncated to fit.
'N	do not print duplicated data for a field.
;Rn	right justify data in a field of 'n' characters. If the data is more than 'n' characters in length, it will NOT be truncated to fit.
;Sn	skip 'n' lines before printing the data for the selected field. You may use ;S to skip a single line (equivalent to ;S1).
;T	use the field title as the header.
;Wn	wrap the output of the selected field in a field of 'n' characters. Breaks will occur at word divisions. Use ;W for default wrapping.
;X	omit the spaces between print fields and suppress the column header.
;Yn	start the output for the selected field at line (row) number 'n'.
;"xxx"	use 'xxx' as the column header.
;""	suppress column header.

Using Sort and Print Prefixes and Suffixes

Now let's take the same report and apply some of the above prefixes and suffixes. To improve the appearance of the report we will do the following:

- Shorten the print field names for Date of Birth and Highest Level of Injury. (Print suffix ";xxx")
- Separate the individual records by skipping a line. (Print suffix ";S")
- (Sort prefix "#")
- Count the number of patients for each provider. (Sort prefix +) (Print prefix &)
- Control where the data is printed for each record. (Print suffix ";Cn")
- Sort and Print the Next Annual Rehab Eval Due date so the records are sorted by due date but it is not a sub-header.

Sort selections:

```
   Sort selection # 1 : #+44;"",40
```

#+44;""	Start a new page for each new Primary Care Provider, count the number of patients for the provider, and suppress printing the sub-heading "Primary Care Provider:"
40	Sort the records within each provider by the date.

```
   Sort by: Primary Care Provider

     Sort from: BEGINNING// <RET>

   Sort by: Next Annual Rehab Eval Due

     Sort from: BEGINNING// 1/1/2000  (JAN 01, 2000)

     Sort to:   ENDING// 1/31/2000  (JAN 31, 2000)
```

Print Selections:

```
   Print selection # 1 : 40;S1;"Date
Due";L12,!1;C15;L25,2;C45,3;"DOB";C60,9;C10; "Level",17,36;C10
```

40;S1;"Date Due";L12	Print the Next Annual Rehab Eval Due so the date will not be a sub-header, skip 1 line between each new date, use "Date Due" as the header, and limit the number of characters printed to 12.
!1;C15;L25	Count each patient for the provider, start printing the patient at column 15, and limit the length of the name to 25 characters.
2;C45	Start printing the SSN in column 45.
3;"DOB";C60	Use "DOB" as the header for Date of birth and start printing in column 60.
9;C10;"Level"	Start printing the SCI Level in column 10 and use "Level" as the header.
17	Print the Etiology
36;C10	Print the Remarks starting in column 10.

```
   Enter special report header, if desired (maximum of 60 characters).


   Include the sort criteria in the header? No// y  (Yes)
Do not queue this report if you used up-front or user selectable filters.

DEVICE: [Enter a device name]
```

```
SCD (SPINAL CORD) REGISTRY STATISTICS          DEC 28,1999  13:40    PAGE 1
Sort Criteria: PRIMARY CARE PROVIDER not null
               NEXT ANNUAL REHAB EVAL DUE from Jan 1,2000 to Jan
31,2000@24:00
Date Due      Patient                        SSN            DOB
         Level                          Etiology
         Remarks
--------------------------------------------------------------------------------

        BELL,KENNY

JAN 10,2000   ARMSTRONG,PA                   445678989      JAN  1,1960
         C05                             ACT OF VIOLENCE
         These are the remarks for this patient.
              ------------------------------
SUBCOUNT      1
```

```
SCD (SPINAL CORD) REGISTRY STATISTICS          DEC 28,1999  13:40    PAGE 2
Date Due      Patient                        SSN            DOB
         Level                          Etiology
         Remarks
--------------------------------------------------------------------------------

        WILLIAMS,MORRIS

JAN  4,2000   LIME,PATIE                     389389467      DEC 12,1912
         L04                             FALL
         These are the remarks for this patient.

JAN  5,2000   CANUSEE,PATI                   444226666      APR  4,1932
         L05                             ARTHRITIC DISEASE OF THE SPINE

              ------------------------------
SUBCOUNT      2
```

```
SCD (SPINAL CORD) REGISTRY STATISTICS          DEC 28,1999  13:40    PAGE 3
Date Due      Patient                        SSN            DOB
         Level                          Etiology
         Remarks
--------------------------------------------------------------------------------

        WILLIAMS,CATHY

JAN  3,2000   HARPER,PAT                     578657687      FEB  6,1941
         T03                             ARTHRITIC DISEASE OF THE SPINE
         These are the remarks for this patient.

JAN  7,2000   BUREN VAN,PATIEN              345660123      OCT  1,1975
         L05                             MULTIPLE SCLEROSIS
         These are the remarks for this patient.
              ------------------------------
SUBCOUNT      2
              ------------------------------
COUNT         5
```

Macro Functions

Now that we have the report the way we want it to look, we want to be able to print out the same report every month. We can use macros to save the design and call it up again.

[L Load sort (and print) macro. You will use this to bring up the macro in order to print your report.

[S Save sort (and print) macro. You cannot build a macro that sorts and prints. You create a sort macro and a print macro.

[O Output macro. The output macro will print a blank ad hoc macro report or one with the fields and modifiers that you have entered. This does not save the entries. There are two ways to obtain a record of both sort and print fields and modifiers: Enter **[O** at the beginning of sort and at the beginning of print. Enter **[O** only at the beginning of the print selections.

[I Inquire sort (and print) macro. This function will let you look at the sort fields or print fields for the macro that you choose.

[D Delete sort (and print) macro. This function deletes any macros that you want to eliminate.

Save Macro

Now let's create a sort and print macro for the report we designed.

```
SCD Ad hoc report for Registry

================ Registration Ad Hoc Report Generator ================

 1 Patient              21 Describe Other         41 Annual Eval Received
 2 SSN                  22 Onset by Trauma        42 Next Annual Eval Due
 3 Date of Birth        23 MS Subtype             43 Last Annual Eval Offered
 4 Date of Death        24 Had Brain Injury?      44 Last Annual Eval Received
 5 Age                  25 Had Amputation?        45 Last Annual Eval Due
 6 Registration Date    26 Memory/Think Affected  46 Primary Care Provider
 7 Registration Status  27 Eyes Affected          47 SCD-Registry Coordinator
 8 Date of Last Update  28 One Arm Affected       48 Referral Source
 9 Last Updated By      29 One Leg Affected       49 Referral VA
10 Division             30 Both Arms Affected     50 Initial Rehab Site
11 SCI Network          31 Both Legs Affected     51 Init Rehab Discharge Date
12 SCI Level            32 Other Body Prt Affected52 Bowel Care Reimbursement
13 VA SCI Status        33 Descr Other Body Part  53 BCR Date Certified
14 [1]Amount VA is Used  34 Extent of Movement     54 BCR Provider
15 Primary Care VAMC    35 Extent of Feeling      55 Sensory/Motor Loss
16 Annual Rehab VAMC    36 Bowel Affected         56 Class of Paralysis
17 Additional Care VAMC 37 Bladder Affected       57 Type of Injury
18 Non-VA Care          38 Remarks                58 Enrollment Priority
19 Etiology             39 Extent of SCI
20 Date of Onset        40 Annual Eval Offered

   Sort selection # 1 :
```

[1] Patch SPN*2.0*19 January 2003 – Revised field selection (fields 14, 47, & 58).

```
 Sort selection # 1 : [Save sort macro]
```
[At the first Sort selection prompt, enter "[S".]

The macro will be saved when you exit the sort menu.

```
================ Registration Ad Hoc Report Generator ================

 1 Patient                  Describe Other         41 Annual Eval Received
 2 SSN                   22 Onset by Trauma        42 Next Annual Eval Due
 3 Date of Birth         23 MS Subtype             43 Last Annual Eval Offered
 4 Date of Death         24 Had Brain Injury?      44 Last Annual Eval Received
 5 Age                   25 Had Amputation?        45 Last Annual Eval Due
 6 Registration Date     26 Memory/Think Affected  46 Primary Care Provider
 7 Registration Status   27 Eyes Affected          47 SCD-Registry Coordinator
 8 Date of Last Update   28 One Arm Affected       48 Referral Source
 9 Last Updated By       29 One Leg Affected       49 Referral VA
10 Division              30 Both Arms Affected     50 Initial Rehab Site
11 SCI Network           31 Both Legs Affected     51 Init Rehab Discharge Date
12 SCI Level             32 Other Body Prt Affected52 Bowel Care Reimbursement
13 VA SCI Status            Descr Other Body Part  53 BCR Date Certified
14 Amount VA is Used     34 Extent of Movement        BCR Provider
15 Primary Care VAMC     35 Extent of Feeling         Sensory/Motor Loss
16 Annual Rehab VAMC     36 Bowel Affected         56 Class of Paralysis
17 Additional Care VAMC  37 Bladder Affected       57 Type of Injury
   Non-VA Care              Remarks                58 Enrollment Priority
19 Etiology              39 Extent of SCI
20 Date of Onset         40 Annual Eval Offered
```

```
   Sort selection # 1 :
 Sort selection # 1 : #+46;"",42        [Enter    your    sort    values.]

   Sort by: Primary Care Provider

     Sort from: BEGINNING// <RET>

   Sort by: Next Annual Rehab Eval Due

     Sort from: BEGINNING// 1/1/2000  (JAN 01, 2000)

     Sort to:   ENDING// 1/31/2000  (JAN 31, 2000)

   Save sort macro name: SPN EVAL DUE
```
[Give the sort macro a name that describes what the macro does.]
```
  Are you adding 'SPN EVAL DUE' as a new AD HOC MACRO? No// Y  (Yes)

   Ask user BEGINNING/ENDING values for Primary Care Provider? No// <RET>
(No)
```
[For this report, we always want all the primary care providers, so we need not enter beginning and ending values].

```
   Ask user BEGINNING/ENDING values for Next Annual Rehab Eval Due? No// Y
  (Yes)
```
[We will always want different date values, so we respond YES to beginning and ending values for the Eval Due date].

```
================ Registration Ad Hoc Report Generator ================

 1 Patient              21 Describe Other         41 Annual Eval Received
 2 SSN                  22 Onset by Trauma        42 Next Annual Eval Due
 3 Date of Birth        23 MS Subtype             43 Last Annual Eval Offered
 4 Date of Death        24 Had Brain Injury?      44 Last Annual Eval Received
 5 Age                  25 Had Amputation?        45 Last Annual Eval Due
 6 Registration Date    26 Memory/Think Affected  46 Primary Care Provider
 7 Registration Status  27 Eyes Affected          47 SCD-Registry Coordinator
 8 Date of Last Update  28 One Arm Affected       48 Referral Source
 9 Last Updated By      29 One Leg Affected       49 Referral VA
10 Division             30 Both Arms Affected     50 Initial Rehab Site
11 SCI Network          31 Both Legs Affected     51 Init Rehab Discharge Date
12 SCI Level            32 Other Body Prt Affected52 Bowel Care Reimbursement
13 VA SCI Status        33 Descr Other Body Part  53 BCR Date Certified
14 [1]Amount VA is Used  34 Extent of Movement     54 BCR Provider
15 Primary Care VAMC    35 Extent of Feeling      55 Sensory/Motor Loss
16 Annual Rehab VAMC    36 Bowel Affected         56 Class of Paralysis
17 Additional Care VAMC 37 Bladder Affected       57 Type of Injury
18 Non-VA Care          38 Remarks                58 Enrollment Priority
19 Etiology             39 Extent of SCI
20 Date of Onset        40 Annual Eval Offered

      Print selection # 1: [Save print macro]
[Enter "[S" to create and save the print macro.]

   The macro will be saved when you exit the print menu.


  ================ Registration Ad Hoc Report Generator ================

 1 Patient              21 Describe Other         41 Annual Eval Received
 2 SSN                  22 Onset by Trauma        42 Next Annual Eval Due
 3 Date of Birth        23 MS Subtype             43 Last Annual Eval Offered
 4 Date of Death        24 Had Brain Injury?      44 Last Annual Eval Received
 5 Age                  25 Had Amputation?        45 Last Annual Eval Due
 6 Registration Date    26 Memory/Think Affected  46 Primary Care Provider
 7 Registration Status  27 Eyes Affected          47 SCD-Registry Coordinator
 8 Date of Last Update  28 One Arm Affected       48 Referral Source
 9 Last Updated By      29 One Leg Affected       49 Referral VA
10 Division             30 Both Arms Affected     50 Initial Rehab Site
11 SCI Network          31 Both Legs Affected     51 Init Rehab Discharge Date
12 SCI Level            32 Other Body Prt Affected52 Bowel Care Reimbursement
13 VA SCI Status        33 Descr Other Body Part  53 BCR Date Certified
14 Amount VA is Used    34 Extent of Movement     54 BCR Provider
15 Primary Care VAMC    35 Extent of Feeling      55 Sensory/Motor Loss
16 Annual Rehab VAMC    36 Bowel Affected         56 Class of Paralysis
17 Additional Care VAMC 37 Bladder Affected       57 Type of Injury
18 Non-VA Care          38 Remarks                58 Enrollment Priority
19 Etiology             39 Extent of SCI
20 Date of Onset        40 Annual Eval Offered

 Print selection # 1 : 42;S1;"Date
Due";L12,!1;C15;L25,2;C45,3;"DOB";C60,19;C10;"Level",12,38;C10
[Enter the print values.]
```

[1] Patch SPN*2.0*19 January 2003 – Revised field selection (fields 14, 47, & 58).

```
   Save print macro name: SPN EVAL DUE
```
[Because these sort and print macros will always go together, we will give them the same names.
***Note:** You can mix and match sort and print macros. You may have a sort macro that you use with several print macros].*

```
  Are you adding 'SPN EVAL DUE' as a new AD HOC MACRO? No// Y  (Yes)

   Enter special report header, if desired (maximum of 60 characters). <RET>

   Include the sort criteria in the header? No// Y  (Yes)
Do not queue this report if you used up-front or user selectable filters.

DEVICE: [Enter a device name]
```

```
SCD (SPINAL CORD) REGISTRY STATISTICS          DEC 29,1999  08:13    PAGE 1
Sort Criteria: PRIMARY CARE PROVIDER not null
               NEXT ANNUAL REHAB EVAL DUE from Jan 1,2000 to Jan
31,2000@24:00
Date Due      Patient                       SSN            DOB
         Level                           Etiology
         Remarks
--------------------------------------------------------------------------------

        BALL,KENNY

JAN 10,2000   ARMSTRONG,PA                  445678989      JAN  1,1960
...
```

Output and Load Macros

You can obtain a printout of the content of the macro by using the "[O" Output Macro command.

At the first Sort selection prompt, enter "[L".

```
   Sort selection # 1 : [Load sort macro]

   Load sort macro name: SPN EVAL DUE

   Sort by: Next Annual Rehab Eval Due

     Sort from: BEGINNING// <RET>
```

At the first Print selection prompt, enter "[O".

```
   Print selection # 1: [Output macro]

   You will be prompted for an output
   device when you exit the print menu.
```

At the next Print selection prompt, enter "[L".

```
   Print selection # 1 : [Load print macro]

   Load print macro name: SPN EVAL DUE

   Output macro to device: HOME// [Enter printer name]
```

```
                    ========================================
                    || AD HOC REPORT GENERATOR MACRO REPORT ||
                    ========================================


Report name: ____________________________________________________________________

Sort fields:
------------

Macro: SPN EVAL DUE

   1) Field: Primary Care Provider
      Entry: #+56;""
      From:  Beginning                      To: Ending

   2) Field: Next Annual Rehab Eval Due
      Entry: 52
      From:  Ask User                       To: Ask User

   3) Field: _____________________________
      Entry: _____________________________
      From:  _____________________________  To: _____________________________

   4) Field: _____________________________
      Entry: _____________________________
      From:  _____________________________  To: _____________________________
Enter RETURN to continue or '^' to exit:

Print fields:
-------------

Macro: SPN EVAL DUE

   1) Field: Next Annual Rehab Eval Due
      Entry: 52;S1;L12;"Date Due"

   2) Field: Patient
      Entry: !1;C15;L25

   3) Field: SSN
      Entry: 2;C45

   4) Field: Date Of Birth
      Entry: 3;C60;"DOB"

   5) Field: SCI Level
      Entry: 9;C10;"Level"

   6) Field: Etiology
      Entry: 17

   7) Field: Remarks
      Entry: 42;C10

Header: ____________________________________________________________________

Sort criteria in report header: Yes          Device: ____________________
```

Inquire Macro

Use the Inquire macro when you are unsure what the macro values are.

```
   Sort selection # 1: [Inquire sort macro]

   Inquire sort macro name: SPN EVAL DUE

Sort macro: SPN EVAL DUE
------------------------
   1) Field: Primary Care Provider
      Entry: #+56;""
      From:  Beginning                        To: Ending
   2) Field: Next Annual Rehab Eval Due
      Entry: 52
      From:  Ask User                         To: Ask User
```

Glossary

ABBREVIATED RESPONSE	This feature allows you to enter data by typing only the first few characters for the desired response. This feature will not work unless the information is already stored in the computer.
ACCESS CODE	A code that allows the computer to identify you as a user authorized to gain access to the computer. Your code is greater than six and less than twenty characters long; can be numeric, alphabetic, or a combination of both; and is usually assigned by a site manager or application coordinator. (See the term **verify code** in the Glossary.)
ADPAC	**A**utomated **D**ata **P**rocessing **A**pplication **C**oordinator
APPLICATION COORDINATOR	Designated individuals responsible for user-level management and maintenance of an application package such as IFCAP, Lab, Pharmacy, Mental Health, etc.
APPLICATION PACKAGE	In V*IST*A, software and documentation that support the automation of a service, such as Laboratory or Pharmacy, within VA medical centers (see the term **Package** in the Glossary). The Kernel is like an operating system relative to other V*IST*A applications.
AUTO-MENU	An indication to Menu Manager that the current user's menu items should be displayed automatically. When auto-menu is not in effect, the user must enter a question mark at the menu's select prompt to see the list of menu items.
BEDSECTION	Also referred to as "Specialty" in this document. Specific services in a hospital have their own floors or rooms where patients can be admitted and monitored by that service. A patient is admitted to the hospital through a particular service, which has its own bedsection (i.e., SCI service has its own bedsection where care and treatment is administered to SCI patients).
CARET	A symbol expressed as up caret (^), left caret (<), or right caret (>). In many M systems, a right caret is used as a system prompt and an up caret as an exiting tool from an option. Also known as the up-arrow symbol or shift–6 key.

CLINICAL ASSESSMENT	Evaluation of a patient's condition by a clinician.
CLINICAL OBSERVATION	Inspection of a patient 's condition by a clinician.
COMMAND	A combination of characters that instruct the computer to perform a specific operation.
COMMON MENU	Options that are available to all users. Entering two question marks at the menu's select prompt displays any secondary menu options available to the signed-on user, along with the common options available to all users.
CONTROL KEY	The Control Key (**Ctrl** on the keyboard) performs a specific function in conjunction with another key. In word-processing, for example, holding down the **Ctrl** key and typing an **A** causes a new set of margins and tab settings to occur; **Ctrl-S** causes printing on the terminal screen to stop; **Ctrl-Q** restarts printing on the terminal screen; **Ctrl-U** deletes an entire line of data entry before the Return key is pressed.
CROSS REFERENCE	An indexing method whereby files can include pre-sorted lists of entries as part of the stored database. Cross-references (x-refs) facilitate look-up and reporting. A file may be cross-referenced to provide direct access to its entries in several ways. For example, VA FileMan allows the Patient file to be cross-referenced by name, social security number, and bed number. When VA FileMan asks for a patient, the user may then respond with the patient's name, social security number, or his bed number. A cross-reference speeds up access to the file, both for looking up entries and for printing reports. A cross-reference is also referred to as an index or cross-index.
CURSOR	A flashing image on your screen (generally a horizontal line or rectangle) that alerts you that the computer is waiting for you to make a response to an instruction (prompt).
DATA	A representation of facts, concepts, or instructions in a formalized manner for communication, interpretation, or processing by humans or by automatic means. The information you enter for the computer to store and retrieve. Characters that are stored in the computer system as the values of local or global variables. VA FileMan fields hold data values for file entries.

DATA ATTRIBUTE	A characteristic of a unit of data such as length, value, or method of representation. VA FileMan field definitions specify data attributes.
DATA DICTIONARY	The Data Dictionary is a global containing a description of what kind of data is stored in the global corresponding to a particular file. The data is used internally by FileMan for interpreting and processing files. A Data Dictionary (DD) contains the definitions of a file's elements (fields or data attributes); relationships to other files; and structure or design. Users generally review the definitions of a file's elements or data attributes; programmers review the definitions of a file's internal structure.
DATA DICTIONARY ACCESS	A user's authorization to write/update/edit the data definition for a computer file. Also known as **DD Access**.
DATA DICTIONARY LISTING	This is the printable report that shows the data dictionary. DDs are used by users and programmers.
DATA PROCESSING	Logical and arithmetic operations performed on data. These operations may be performed manually, mechanically, or electronically: sorting through a card file by hand would be an example of the first method; using a machine to obtain cards from a file would be an example of the second method; and using a computer to access a record in a file would be an example of the third method.
DATABASE	A set of data, consisting of at least one file, that is sufficient for a given purpose. The VISTA database is composed of a number of VA FileMan files. A collection of data about a specific subject, such as the PATIENT file; a data collection has different data fields (e.g., patient name, SSN, Date of Birth, and so on). An organized collection of data about a particular topic.
DATABASE MANAGEMENT SYSTEM	A collection of software that handles the storage, retrieval, and updating of records in a database. A **D**ata**b**ase **M**anagement **S**ystem (DBMS) controls redundancy of records and provides the security, integrity, and data independence of a database.
DATABASE, NATIONAL	A database, which contains data, collected or entered for all VHA sites.
DBA	**D**ata**b**ase **A**dministrator, oversees package development with respect to V*IST*A Standards and Conventions (SAC) such as namespacing. Also, this term refers to the **D**ata**b**ase **Administration** function and staff.

DBIA	**D**ata**b**ase **I**ntegration **A**greement, a formal understanding between two or more V*IST*A packages which describes how data is shared or how packages interact. The DBA maintains a list of DBIAs.
DBIC	**D**ata**b**ase **I**ntegration **C**ommittee. Within the purview of the DBA, the committee maintains a list of DBIC approved callable entry points and publishes the list on FORUM for reference by application programmers and verifiers.
DEBUG	To correct logic errors or syntax errors or both types in a computer program. To remove errors from a program.
DEFAULT	A response the computer considers the most probable answer to the prompt being given. It is identified by double slash marks (//) immediately following it. This allows you the option of accepting the default answer or entering your own answer. To accept the default you simply press the enter (or return) key. To change the default answer, type in your response.
DELETE	The key on your keyboard (may also be called rubout or backspace on some terminals) which allows you to delete individual characters working backwards by placing the cursor immediately after the last character of the string of characters you wish to delete. The @ sign (uppercase of the 2 key) may also be used to delete a file entry or data attribute value. The computer asks "Are you sure you want to delete this entry?" to insure you do not delete an entry by mistake.
DELIMITER	A special character used to separate a field, record or string. VA FileMan uses the ^ character as the delimiter within strings.
DEVICE	A peripheral connected to the host computer, such as a printer, terminal, disk drive, modem, and other types of hardware and equipment associated with a computer. The host files of underlying operating systems may be treated like devices in that they may be written to (e.g., for spooling).
DICTIONARY	A database of specifications of data and information processing resources. VA FileMan's database of data dictionaries is stored in the FILE of files (#1).
DISK	The media used in a disk drive for storing data.

DISK DRIVE	A peripheral device that can be used to “read” and “write” on a hard or floppy disk.
DOUBLE QUOTE (")	A symbol used in front of a Common option’s menu text or synonym to select it from the Common menu. For example, the five character string "TBOX" selects the User’s Toolbox Common option.
DSCC	**D**ocumentation **S**tandards and **C**onventions **C**ommittee. Package documentation is reviewed in terms of standards set by this committee.
DUZ	A local variable holding the user number that identifies the signed-on user.
DUZ(0)	A local variable that holds the File Manager Access Code of the signed-on user.
ENCRYPTION	Scrambling data or messages with a cipher or code so that they are unreadable without a secret key. In some cases encryption algorithms are one directional, that is, they only encode and the resulting data cannot be unscrambled (e.g., access/verify codes).
ENTER	Pressing the return or enter key tells the computer to execute your instruction or command or to store the information you just entered.
ENTRY	A VA FileMan record. It is uniquely identified by an internal entry number (the .001 field) in a file.
ETIOLOGY	The study or theory of the factors that cause disease and the method of their introduction to the host; the cause(s) or origin of a disease or disorder.
EXPERT PANEL	Representative users from the field and Program Office who make recommendations for software development. The Expert Panels (EPs) report to and are formed by the ARGs.
EXTRACTOR	A specialized routine designed to scan data files and copy or summarize data for use by another process.

FIELD	In a record, a specified area used for the value of a data attribute. The data specifications of each VA FileMan field are documented in the file's data dictionary. A field is similar to blanks on forms. It is preceded by words that tell you what information goes in that particular field. The blank, marked by the cursor on your terminal screen, is where you enter the information.
FILE	A set of related records treated as a unit. VA FileMan files maintain a count of the number of entries or records.
FILE MANAGER (VA FILEMAN)	The V*IST*A's Database Management System (DBMS). The central component of the Kernel that defines the way standard V*IST*A files are structured and manipulated.
FOIA	The **F**reedom **O**f **I**nformation **A**ct. Under the provisions of this public law, software developed within the VA is made available to other institutions, or the general public, at a nominal cost.
FORCED QUEUING	A device attribute indicating that the device can only accept queued tasks. If a job is sent for foreground processing, the device rejects it and prompts the user to queue the task instead.
FREE TEXT	The use of any combination of numbers, letters, and symbols when entering data.
GLOBAL VARIABLE	A variable that is stored on disk (M usage).
GO-HOME JUMP	A menu jump that returns the user to the Primary menu presented at sign-on. It is specified by entering two up-arrows (^^) at the menu's select prompt. It resembles the rubber band jump but without an option specification after the up-arrows.
HARDWARE	The physical equipment pieces that make up the computer system (e.g., terminals, disk drives, central processing units). The physical components of a computer system.
HEALTH SERVICES RESEARCH & DEVELOPMENT (HSR&D)	Established in 1973 to assist in the search for the most cost-effective approaches to delivering quality health care to the nation's veterans through the support of health services research studies.

HELP FRAMES	Entries in the HELP FRAME file that may be distributed with application packages to provide on-line documentation. Frames may be linked with other related frames to form a nested structure.
HELP PROMPT	The brief help that is available at the field level when entering one question mark.
HINQ	**H**ospital **INQ**uiry. A system that permits medical centers to query the Veterans Benefits Administration systems via the VADATS network.
HIS	**H**ospital **I**nformation **S**ystems
ICD	**I**nternational **C**lassification of **D**iseases
IFCAP	**I**ntegrated **F**unds Distribution, **C**ontrol Point Activity, **A**ccounting, and **P**rocurement
IHS	**I**ndian **H**ealth **S**ervice
IHS	**I**ntegrated **H**ospital **S**ystem
INPATIENT	A patient who has been admitted to a hospital in order to be treated for a particular condition.
KERNEL	A set of V*IST*A software routines that function as an intermediary between the host operating system and the V*IST*A application packages such as Laboratory, Pharmacy, IFCAP, etc. The Kernel provides a standard and consistent user and programmer interface between application packages and the underlying M implementation.
KEY	The purpose of Security Keys is to set a layer of protection on the range of computing capabilities available with a particular software package. The availability of options is based on the level of system access granted to each user.

KEYWORD	A word or phrase used to call up several codes from the reference files in the LOCAL LOOK-UP file. One specific code may be called up by several different keywords.
LAYGO ACCESS	A user's authorization to create a new entry when editing a computer file. (**L**earn **A**s **Y**ou **GO** allows you the ability to create new file entries.)
LINK	Non-specific term referring to ways in which files may be related (via pointer links). Files have links into other files.
LOG IN/ON	The process of gaining access to a computer system.
LOG OUT/OFF	The process of exiting from a computer system.
MAIL MESSAGE	An entry in the MESSAGE file. The V*IST*A electronic mail system (MailMan) supports local and remote networking of messages.
MAILMAN	An electronic mail system that allows you to send and receive messages from other users via the computer.
MANAGER ACCOUNT	A UCI that can be referenced by non-manager accounts such as production accounts. Like a library, the MGR UCI holds percent routines and globals (e.g., ^%ZOSF) for shared use by other UCIs.
MANDATORY FIELD	This is a field that requires a value. A null response is not valid.
MEDICAL CARE COST RECOVERY (MCCR)	A VA project to collect data from entities which owe payment to VA for care of patients. Also referred to by the acronym MCCR.
MENU	A list of choices for computing activity. A menu is a type of option designed to identify a series of items (other options) for presentation to the user for selection. When displayed, menu-type options are preceded by the word "Select" and followed by the word "option" as in Select Menu Management option: (the menu's select prompt).

MENU CYCLE	The process of first visiting a menu option by picking it from a menu's list of choices and then returning to the menu's select prompt. Menu Manager keeps track of information, such as the user's place in the menu trees, according to the completion of a cycle through the menu system.
MENU SYSTEM	The overall Menu Manager logic as it functions within the Kernel framework.
MENU TEMPLATE	An association of options as pathway specifications to reach one or more final destination options. The final options must be executable activities and not merely menus for the template to function. Any user may define user-specific menu templates via the corresponding Common option.
MENU TEXT	The descriptive words that appear when a list of option choices is displayed. Specifically, the Menu Text field of the OPTION file. For example, User's Toolbox is the menu text of the XUSERTOOLS option. The option's synonym is TBOX.
MS	Multiple Sclerosis.
NATIONAL SPINAL CORD DYSFUNCTION (SCD) REGISTRY	This V*IST*A package consists of two major components: 1) a local registry for use within a VA health care facility, and 2) a National Registry reflecting the events of care for patients at all VA facilities.
NUMERIC FIELD	A response that is limited to a restricted number of digits. It can be dollar valued or a decimal figure of specified precision.
OPERATING SYSTEM	A basic program that runs on the computer, controls the peripherals, allocates computing time to each user, and communicates with terminals.
OPTION	An entry in the OPTION file. As an item on a menu, an option provides an opportunity for users to select it, thereby invoking the associated computing activity. Options may also be scheduled to run in the background, non-interactively, by TaskMan.
OPTION NAME	The Name field in the OPTION file (e.g., XUMAINT for the option that has the menu text "Menu Management"). Options are namespaced according to V*IST*A conventions monitored by the DBA.

OUTPATIENT	A patient who comes to the hospital, clinic, or dispensary for diagnosis and/or treatment but does not occupy a bed.
PACKAGE	The set of programs, files, documentation, help prompts, and installation procedures required for a given software application. For example, Laboratory, Pharmacy, and MAS are packages. A V*IST*A software environment composed of elements specified via the Kernel's Package file. Elements include files and associated templates, namespaced routines, and namespaced file entries from the Option, Key, Help Frame, Bulletin, and Function files. Packages are transported using VA FileMan's DIFROM routine that creates initialization routines to bundle the files and records for export. Installing a package involves the execution of initialization routines that create the required software environment. Verified packages include documentation. As public domain software, verified packages may be requested through the Freedom of Information Act (FOIA).
PARALYZED VETERANS OF AMERICA (PVA)	A congressionally chartered veterans service organization founded following World War II, has developed a unique expertise in a wide variety of issues involving the needs of its members—veterans of the armed forces who have experienced spinal cord injury or dysfunction.
PASSWORD	A user's secret sequence of keyboard characters, which must be entered at the beginning of each computer session to provide the user's identity.
PERIPHERAL DEVICE	Any hardware device other than the computer itself (central processing unit plus internal memory). Typical examples include card readers, printers, CRT units, and disk drives.
PHANTOM JUMP	Menu jumping in the background. Used by the menu system to check menu pathway restrictions.
POINTER	A relationship between two VA FileMan files, a pointer is a file entry that references another file (forward or backward).
PRIMARY MENUS	The list of options presented at sign-on. Each user must have a primary menu in order to sign-on and reach Menu Manager. Users are given primary menus by IRM. This menu should include most of the computing activities the user needs.
PRINTER	A printing or hard copy terminal.

PRODUCTION ACCOUNT	The UCI where users log on and carry out their work, as opposed to the manager, or library, account.
PROGRAM	A list of instructions written in a programming language and used for computer operations.
PROMPT	The computer interacts with the user by issuing questions called **prompts**, to which the user issues a response.
PVA	**P**aralyzed **V**eterans of **A**merica—a congressionally chartered veterans service organization founded following World War II, has developed a unique expertise in a wide variety of issues involving the needs of its members—veterans of the armed forces who have experienced spinal cord injury or dysfunction.
QUEUING	Requesting that a job be processed in the background rather than in the foreground within the current session. Jobs are processed sequentially (first-in, first-out). The Kernel's Task Manager handles the queuing of tasks.
QUEUING REQUIRED	An option attribute that specifies that the option must be processed by TaskMan (the option can only be queued). The option may be invoked and the job prepared for processing, but the output can only be generated during the specified time periods.
READ ACCESS	A user's authorization to read information stored in a computer file.
RECORD	A set of related data treated as a unit. An entry in a VA FileMan file constitutes a record. A collection of data items that refer to a specific entity (e.g., in a name-address-phone number file, each record would contain a collection of data relating to one person).
RESOURCE	Sequential processing of tasks can be controlled through the use of resources. Resources are entries in the DEVICE file which must be allocated to a process(es) before that process can continue.
RETURN	On the computer keyboard, the key located where the carriage return is on an electric typewriter. It is used in V*ISTA* to terminate "reads." Symbolized by <RET>.

SCHEDULING OPTIONS	This is a technique of requesting that TaskMan run an option at a given time, perhaps with a given rescheduling frequency.
SCI	**S**pinal **C**ord **I**njury.
SCI CENTERS	First established in 1946, these centers coordinate and administer the long-term care and treatment of spinal cord injured veterans.
SCI COORDINATOR	A social worker who identifies SCI patients, evaluates their socioeconomic status and advises them on eligibility criteria for VA benefits. SCI coordinators and other field personnel are the primary users of the local registries.
SCI LEVEL	Pertains to the vertebra and specific area of the spine affected or impaired by a disease or injury (e.g., Cervical: C01–C08, Thoracic: T01–T12; Lumbar: L01–L05; Sacral: S01–S05).
SCI PATIENTS	Patients whose spinal cord has been impaired due to trauma.
SCREEN	A CRT, monitor or video display terminal
SECONDARY MENUS	Options assigned to individual users to tailor their menu choices. If a user needs a few options in addition to those available on the Primary menu, the options can be assigned as secondary options. To facilitate menu jumping, secondary menus should be specific activities, not elaborate and deep menu trees.
SECURITY KEY	The purpose of Security Keys is to set a layer of protection on the range of computing capabilities available with a particular software package. The availability of options is based on the level of system access granted to each user.
SERVER	An entry in the OPTION file. An automated mail protocol that is activated by sending a message to a server at another location with the "S.server" syntax. This activity is specified in the OPTION file.
SET OF CODES	Usually a preset code with one or two characters. The computer may require capital letters as a response (e.g., M for male and F for female). If anything other than the acceptable code is entered, the computer rejects the response.

SIGN-ON/SECURITY	The Kernel module that regulates access to the menu system. It performs a number of checks to determine whether access can be permitted at a particular time. A log of sign-ons is maintained.
SITE MANAGER/ IRM CHIEF	At each site, the individual who is responsible for managing computer systems, installing and maintaining new modules, and serving as liaison to the ISCs.
SPACEBAR RETURN	You can answer a VA FileMan prompt by pressing the spacebar and then the Return key. This indicates to VA FileMan that you would like the last response you were working on at that prompt recalled.
SPECIAL QUEUING	An option attribute indicating that TaskMan should automatically run the option whenever the system reboots.
SPECIALTY	The particular subject area or branch of medical science to which one devotes professional attention.
SPINAL CORD DYSFUNCTION (SCD)	Specified diseases and conditions that result in an impairment or abnormality of the spinal cord and/or cauda equina. Specified list includes conditions of both traumatic and nontraumatic etiology.
SPINAL CORD INJURY (SCI)	Damage to the spinal cord as a result of a traumatic incident. Trauma is a sudden external force which damages the spinal cord. This includes surgical trauma (i.e., which is both sudden and external) but excludes sudden damage to the vertebrae caused by disease (i.e., the disease process is not sudden). If both traumatic and non traumatic causes are present, classify as traumatic.
SPOOLER	Spooling (under any system) provides an intermediate storage location for files (or program output) for printing at a later time. In the case of V*IST*A, the Kernel manages spooling so that the underlying OS mechanism is transparent. The Kernel subsequently transfers the text to the ^XMBS global for despooling (printing).
STOP CODE	A number (i.e., a subject area indicator) assigned to the various clinical, diagnostic, and therapeutic sections of a facility for reporting purposes. For example, all outpatient services within a given area (e.g., Infectious Disease, Neurology, and Mental Hygiene—Group) would be reported to the same clinic stop code.

SYNONYM	A field in the OPTION file. Options may be selected by their menu text or synonym (see Menu Text).
TASKMAN	The Kernel module that schedules and processes background tasks (also called Task Manager).
TEMPLATE	A means of storing report formats, data entry formats, and sorted entry sequences. A template is a permanent place to store selected fields for use at a later time. Edit sequences are stored in the INPUT TEMPLATE file, print specifications are stored in the PRINT TEMPLATE file, and search or sort specifications are stored in the SORT TEMPLATE file.
TERMINAL	May be either a printer or CRT/monitor/video display terminal.
TIMED-READ	The amount of time a READ command waits for a user response before it times out.
TREE STRUCTURE	A term sometimes used to describe the structure of an M array. This has the same structure as a family tree, with the root at the top and ancestor nodes arranged below according to their depth of subscripting. All nodes with one subscript are at the first level, all nodes with two subscripts at the second level, and so on.
TRIGGER	A type of VA FileMan cross reference. Often used to update values in the database given certain conditions (as specified in the trigger logic). For example, whenever an entry is made in a file, a trigger could automatically enter the current date into another field holding the creation date.
TYPE-AHEAD	A buffer used to store characters that are entered before the corresponding prompt appears. Type-ahead is a shortcut for experienced users who can anticipate an expected sequence of prompts.
UP-ARROW JUMP	In the menu system, entering an up-arrow (^) followed by an option name accomplishes a jump to the target option without needing to take the usual steps through the menu pathway.

USER ACCESS	This term is used to refer to a limited level of access, to a computer system, which is sufficient for using/operating a package, but does not allow programming, modification to data dictionaries, or other operations that require programmer access. Any option, for example, can be locked with the key XUPROGMODE, which means that invoking that option requires programmer access. The user's access level determines the degree of computer use and the types of computer programs available. The Systems Manager assigns the user an access level.
USER INTERFACE	The way the package is presented to the user—issuing of prompts, help messages, menu choices, etc. A standard user interface can be achieved by using VA FileMan for data manipulation, the menu system to provide option choices, and VA FileMan's Reader, the ^DIR utility, to present interactive dialogue.
VA	The Department of **V**eterans **A**ffairs, formerly called the **V**eterans **A**dministration.
VA FILEMAN	A set of programs used to enter, maintain, access, and manipulate a database management system consisting of files. A package of on-line computer routines written in the M language which can be used as a stand-alone database system or as a set of application utilities. In either form, such routines can be used to define, enter, edit, and retrieve information from a set of computer stored files.
VERIFY CODE (SEE PASSWORD)	An additional security precaution used in conjunction with the Access Code. Like the Access Code, it is also 6 to 20 characters in length and, if entered incorrectly, will not allow the user to access the computer. To protect the user, both codes are invisible on the terminal screen.

VISTA	**V**eterans Health **I**nformation **S**ystems and **T**echnology **A**rchitecture, formerly **D**ecentralized **H**ospital **C**omputer **P**rogram of the Veterans Health Administration (VHA), Department of Veterans Affairs (VA). V*IST*A software, developed by VA, is used to support clinical and administrative functions at VA Medical Centers nationwide. It is written in M and, via the Kernel, runs on all major M implementations regardless of vendor. V*IST*A is composed of packages which undergo a verification process to ensure conformity with namespacing and other V*IST*A standards and conventions.